DRAFT REPORT

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES,
AND SUBSTANCE ABUSE SERVICES

REPORT TO THE 2006 REGULAR SESSION
OF THE
2005 GENERAL ASSEMBLY

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TABLE OF CONTENTS

Appendices

JOINT LEGISLATIVE COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
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Raleigh, North Carolina 27603

Senator Martin Nesbitt, Co-Chair *Representative Verla Insko Co-Chair*

May 10, 2006

TO THE MEMBERS OF THE 2005 GENERAL ASSEMBLY (2006 Regular Session):

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services submits to you for your consideration its report pursuant to G.S. 120-231.

Respectfully Submitted,

Rep. Verla Insko, Co-Chair	Sen. Martin Nesbitt, Co-Chair

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PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC was charged with examining, on a continual basis, the system-wide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and quality of services. The Committee consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two must be members of the Senate Committee on Appropriations, the chair of the Senate Appropriations Committee on Human Resources and at least two must be of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. The Co-Chairs for 2005-2006 are Senator Martin Nesbitt and Representative Verla Insko.

COMMITTEE PROCEEDINGS

LEGISLATIVE OVERSIGHT COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on nine occasions during the 2006 interim. The following is a brief summary of the (LOC) Committee's proceedings. Detailed minutes and information from each Committee meeting is available in the Legislative Library and on the Oversight Committee webpage at http://www.ncleg.net/.

September 21, 2005

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services convened its first meeting of the interim on Wednesday, September 21, 2005, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Kory Goldsmith, Research Division and Lisa Hollowell, Fiscal Research Division, presented an overview of the historical context and current goals of mental health reform in North Carolina as enacted in by House Bill 381 - the Mental Health System Reform Bill.

Ms. Goldsmith identified the role of the local management entities (LME) in managing services and Ms. Hollowell explained the purpose and uses of the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding and gave the total appropriations since FY 2000-2001 with adjustments and expenditures.

Regarding the downsizing of state institutions, Ms. Hollowell said that the idea was to shift funding from state institutions into the community as downsizing occurred. She then reviewed a chart showing a total of 414 beds in the State's psychiatric hospitals closed to date, and 33 Area Programs/LMEs in place as of July 1, 2005, down from 40 Area Programs in 2001.

Leza Wainwright, Deputy Director of the Division on Mental Health, Developmental Disabilities and Substance Abuse Services (DMH), then gave an update on activities relating to mental health reform efforts since the last committee meeting on January 18, 2005, and reviewed the Mental Health Trust Fund expenditures for the year.

Representative Insko, Co-Chair, then asked the following stakeholders to provide the Committee with their comments: Consumer and family members – Betty Stansberry, DD; Louise Fisher, MH and Jeff McLoud, MH; LMEs – Grayce Crockett, Mecklenburg; Joy Futrell, Rowan/Chowan and Tom McDevitt, Smokey Mountain;

County Commissioners – Patrice Roesler; Advocates – John Tote, MH Association of N.C.; Dave Richard, ARC of N.C.; Providers – Sarah Wiltgen, Brynn Marr Behavioral Healthcare; Trish Hussy, Freedom House; Jill Keel, Autism Society of N.C.; Robin Huffman, N.C. Psychological Association; Suzie Kennedy, Life Enrichment Center of Cleveland County; and Toni Camp, RN, Life Enrichment Center of Cleveland County; Dan Herr, CFAC. Bob Hedrick, Providers Council, had handouts but did not address the group.

October 19, 2005

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services held its second meeting on Wednesday, October 19, 2005, at 9:00 A.M. at the Renaissance Hotel in Asheville, North Carolina.

Senator Martin Nesbitt, Co-Chair, introduced Larry Thompson and Beth Melcher, consultants hired on a part-time basis to give the LOC their administrative and clinical perspectives on the State MH/DD/SAS system and the current reform efforts.

Lisa Hollowell, Fiscal Research Division, addressed questions from the September 21st meeting and reviewed ways the Mental Health Trust Fund may be used in the reform effort.

Shawn Parker, Research Analyst, gave a synthesis of public comments from the September 21st meeting, identifying areas of progress, areas of concern, and recommendations of stakeholders.

Representative Insko, Co-Chair, reviewed a proposal for LOC work priorities during the interim, noting that two major areas of concern were the capacity and resources at the LME and Division levels to manage the system and the capacity to deliver services.

Kory Goldsmith, Research Division, gave an overview of the LME role regarding management and utilization review. G.S. 122C-141(a), changes the role of area programs from one of service providers to managers of services. G.S. 122C-115.2(b)(1), provides the structure of the LME business plan, which governs how LMEs implement their management roles.

David Swann, Director of Crossroads Behavioral Healthcare serving Iredell, Surry and Yadkin Counties, gave an LME perspective on reform, reviewing the nine key functions of Crossroads' operational activities and described how access, screening, triage and referral (STR) and the utilization review (UR) and service management functions are provided at Crossroads.

Allyn Guffey, Acting Assistant Secretary for Finance and Business Operations for (DHHS), addressed the Secretary's proposal to centralize UR and STR functions and reduce funding for the Department of Health and Human Services LME functions. He gave a brief background of the system before reform explaining that the formula developed to project the cost of the LME functions was based on 20 LMEs.

Senator Nesbitt then asked for public comments. The following members of the public addressed the LOC: Jerry Rice, Mona and David Cornwell, Will Callison, Jere

Annis, Emma Thorne, Billie Gilfillan, Chris Melton, Dennis Huntley, Howard Graves, Paula Cox, Sharon Thomas, Laurie Coker, Patricia McGivens, Nancy Baker, Julie Millain, and Cherie Novak. The speakers expressed their needs and concerns as MH/DD/SAS consumers and family members regarding reform.

Leza Wainwright, Deputy Director, DMH, then gave a report on the Mental Health Trust Fund, showing anticipated expenditures of $24.7 million for fiscal year 2005-2006, all of which are expected to be used during that time.

Mike Moseley, Director, DMH, gave a further explanation of the Secretary's proposal for Regional Utilization Review and centralized screening, triage and referral services, explaining that reform legislation envisioned moving from 40 area programs to 20 LMEs and that shifting certain management functions to a regional level is expected to create efficiencies.

Kitty Barnes, Chair of the Catawba County Board of Commissioners and President of the N.C. County Commissioners Association, provided a response to the Secretary's proposal. She explained the involvement of the counties in the communities– providing funding, administrative functions, physical locations for some LMEs and oversight of the jails and voiced concern that the timeframe for consolidation of the UR function (by December 15, 2005) could make continued provision of services by her LME difficult.

David Swann, responding to the Secretary's proposal, voiced concern about the short time frame for the regional UR consolidation. He also stated that the North Carolina Council of Community Programs believes the proposal is premature.

November 9, 2005

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services held its third meeting on Wednesday, November 9, 2005, at 9:00 A.M. in Room 544 of the Legislative Office Building.

Ben Popkin, Research Division, gave a presentation on the law addressing LME organization and governance structures, both pre and post-reform. Of the six options available, only one (the multi-county county program) requires a catchment area of at least 200,000 in population or a minimum of 5 counties.

Shawn Parker, Research Division, gave an historic and current configuration of area and county programs, providing the committee with maps of LME configurations in both 1997 (41 area programs with populations ranging from 56,000 to 770,000) and present day (29 catchment areas with populations ranging from 75,000 to 770,000). Mr. Parker then reviewed progress since last year's report, highlighting service array, LME functions and the status of the State institutions.

Lisa Hollowell, Fiscal Research Division, gave a presentation on developing management capacity, detailing the LME functions and the allocations based on the Cost Model SFY 2005-2006 and showing the total amounts allocated for the nine functions performed by each LME.

Kory Goldsmith, Research Division, then gave a broad explanation of powers and duties of the Secretary of Health and Human Services, including development of the State Plan, oversight of the operation of State facilities, administration of the Mental Health Trust Fund, monitoring and oversight of the LMEs, and the protection of client rights.

Flo Stein, Chief of Community Policy Management, DMH, explained the Division's role in assisting LMEs with key function implementation, explaining that much attention is being focused on the provider community in the areas of payment, quality of services, provider management governance and infrastructure.

Dr. Michael Lancaster, Chief of Clinical Policy, DMH, gave an overview of Crisis/Emergency Services, explaining how crisis services are provided in the overall reform system. He reviewed the screening process, explained the difference in the 3 levels of crisis services - emergent, urgent and routine, and stressed the importance of a community-based hospital that participates in the mental health system.

Marti Wagner, Regional Director of Operations for Telecare Corporation, working primarily with Durham Center ACCESS as well as the Crisis Recovery Centers at Kannapolis and Statesville, gave a presentation as a provider of crisis services, focusing on programs and implementation, outcomes, challenges and barriers to crisis services.

Julie Sinclair, Crisis Services Director for Southeastern Regional MHDDSAS, reviewed the establishment and current operations of mobile crisis services in her area.

Mike Moseley, Director, DMH, gave an update on the Secretary's Regional UR proposal, pointing out the foundation that created the cost model and stating that the LMEs have been unable or unwilling to achieve the economies of scale assumed by the model.

Carol Clayton, Director of the N.C. Council of Community Programs, responded to the Secretary's proposal by requesting that the Secretary consider four points: 1) allow local communities to make their own decisions about how to best partner and create more efficiencies; 2) allow LMEs adequate time to digest the information and to make changes; 3) provide specific information regarding the target the Secretary is trying to achieve and how much money must be spent on the management function; and 4) work together to create efficiencies in order to reallocate dollars.

Patrice Roesler from the Association of County Commissioners, responded to the Secretary's proposal, encouraging members to look at the public value financial accountability, additional oversight gained by having proximity to the clients, and the number of counties in each proposed region.

December 14, 2005

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services held its fourth meeting on Wednesday, December 14, 2005, at 12:30 P.M. in Room 544 of the Legislative Office Building.

Lisa Hollowell, Fiscal Research Division, gave a presentation on cash flow issues, addressing cash flow problems at the State, LME, and provider levels.

Senator Nesbitt, Co-Chair, announced that an Advisory Committee made up of three House members and three Senate members would be appointed to the LOC. He welcomed Senator Larry Shaw to the meeting. Advisory members have an interest in the issues, but serve as non-voting members who otherwise participate fully.

Kory Goldsmith, Research Division, provided an overview of the reform legislation addressing the core services of screening, assessment, and referral. Twenty-five of the twenty-nine LMEs had signed a performance contract with the State for 2004-2007 that further specifies their obligations for these core services.

Susan Campbell, Manager of Access and Care Management of the Guilford Center, spoke about an LME's experience in developing an access line and providing this service. She introduced Jeff McCloud of the N.C. Mental Health Consumers Organization who demonstrated how the access line worked by calling the Guilford Center's 1-800 number. The committee listened to a conversation between Mr. McCloud and a trained call center representative.

Committee members then listened to a discussion by LME directors and medical directors regarding the factors and barriers affecting the development of LME functions. The panel included: Joy Futrell, Area Director, Roanoke-Chowan Human Services Center; Ms. Ellen S. Holliman, Area Director, Durham Center; Dr. Beth Stanton, Medical Director, New Vistas Behavioral Health Service, Asheville; and Mr. Michael Watson, Area Director, Sandhills Center.

Mike Moseley, Director, DMH, then gave a Division update on regional UR and the status of the Medicaid State Plan amendment. He explained that the Federal Centers for Medicare and Medicaid Services (CMS) delay is the approval of the new Service Definitions continued to be a major destabilizing issue.

January 26, 2006

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services held its fifth meeting on Thursday, January 26, 2006, at 9:30 A.M. in Room 643 of the Legislative Office Building.

Representative Insko, Co-Chair, asked Leza Wainwright, Deputy Director, DMH, to come forward and give an overview of community services for the Developmental Disabilities (DD) population. Ms. Wainwright began with an explanation of the topics covered in her presentation, explaining how DD was defined in G.S. 122C-3(12a) and listed the State funded services for DD. Ms. Wainwright then reviewed the Medicaid funded DD services explaining the criteria for ICF/MR (Intermediate Care Facility/Mental Retardation) eligibility and the guidelines for Home and Community Based waivers. The average cost per person, per waiver last year was $43,000 and the average for ICF/MR was $86,000.

Diann Irvin, Section Chief, Behavioral Support Services with the Department of Public Instruction, addressed how public schools were going to identify those children who would lose CBS services in schools and how the services might be replaced.

Dave Richard, Director of the ARC of North Carolina and representing the DD Consortium, said that the Consortium responded favorably to the Department's plan to replace CBS services, but expressed concern over the short amount of time the LMEs, provider organizations, and State agencies had for implementation.

Representative Insko then asked a panel consisting of a consumer, a provider, a family member and advocates to give their experiences with community services for the DD population. Jill Hinton Keel, Director of the Autism Society of North Carolina, Kathy Bryan, Director of Orange Enterprises, Laura Gorycki, an advocate for individuals and families from the Enrichment Center in Winston-Salem, Jim Woolsey, a parent of a developmentally disabled son, and Rose Reaves, a consumer, participated in the panel.

Mike Moseley, Director, DMH, gave an update on the CMS approval of the new service definitions and stated that the new services would become effective March 20, 2006. Mr. Moseley briefly covered the Provider endorsement process and said that since the State Plan amendment was approved, 646 providers had been endorsed statewide. Mr. Moseley then gave an update on the Secretary's proposal for regional Utilization Review (UR) and Screening, Triage and Referral (STR), providing an estimated net cost savings of $14.5 million in State dollars.

Leza Wainwright, Deputy Director, DMH, addressed the requirements of the use of non-Medicaid funds. She addressed the ability of LMEs to shift funds from one age/disability category to another.

February 16, 2006

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services held its sixth meeting on Thursday, February 16, 2006, at 9:00 A.M. in Room 643 of the Legislative Office Building.

Leza Wainwright, Deputy Director, DMH, reviewed the new and modified service definitions for adults and children with mental illness. She stated that the new service definitions would go into effect March 20, 2006 because according to CMS requirements, the definitions have to be implemented in the same quarter in which they are approved. Ms. Wainwright then spoke about a range of service definitions and discussed a wide range of anticipated issues in implementing those definitions.

Senator Nesbitt, Co-Chair, asked panelists to comment on barriers, challenges and recommendations to developing service capacity for mental health services. The panelists were: Becky Faucette, a family member of an adult with mental illness; Charles Davis, Director, NC Mentor; Anita Harrison, a parent of a child with a mental illness; and Tisha Gamboa, a consumer of mental health services and Executive Director of the NC Mental Health Consumers' Organization.

Senator Nesbitt then asked the substance abuse services panelists to come forward with their comments regarding barriers, challenges and recommendations. Panelists included: Margaret Stargell, CEO of Coastal Horizons; Tamiko Cory consumer in recovery; Larry Coley, consumer in recovery; and Tim Hall, Chair of the Substance Abuse Federation.

Senator Nesbitt then asked the following panelists to comment on the role of consumers in reform: Dan Herr, Chair, Orange-Person-Chatham County (Consumer and Family Advisory Committee) CFAC; Jeff McLoud, Vice President, NC Mental Health Consumer's Organization; Carol Matthieu, Member of Rockingham County CFAC; and Ron Huber, Member, State CFAC.

Arey Grady, board member of the Neuse Center LME, gave comments regarding the role of the local board in reform and identified challenges facing local boards.

Flo Stein, Chief of Community Policy Management, DMH, then spoke on the new service definitions for Substance Abuse Services, noting that the new definitions would include a more credentialed workforce and generate more Medicaid funding than is currently available.

March 22, 2006

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services held its seventh meeting on Wednesday, March 22, 2006, at 9:00 A.M. in Room 643 of the Legislative Office Building,

Carol Shaw, Fiscal Research Division, gave a presentation on Medicaid eligibility criteria and presented case studies to clarify what types of individuals and situations would and would not qualify for Medicaid coverage.

Lisa Hollowell, Fiscal Research Division, reviewed the 2-year historical budget information for DMH and presented the authorized budget of the current year. Ms. Hollowell then defined the target populations in each of the disability groups and the types of services available to those persons.

Ms. Hollowell then explained the method and assumptions she used in calculating an estimation of need for additional funding in North Carolina. She also explained a chart showing 2005 year-end service data listing each LME, the total population served, the year-end budget and expenditures, service dollar allocation per capita, and the average spent on services per client. Ms. Hollowell then gave an update on State Psychiatric hospital downsizing, reviewing the provisions of law showing the direction the General Assembly provided regarding savings and recurring and non-recurring savings that are generated from the closure of beds and reviewed the annual recurring savings.

Kory Goldsmith, Research Division, gave a review of the special provisions regarding various studies DMH had been directed to undertake, including a study of the financing of the MHDDSAS system originally due July 1, 2005, now due March 1, 2006.

Phillip Hoffman, Chief of Resource/Regulatory Management, DMH, apologized for the delay of the Finance Study report and provided members with an update and an estimated June 2006 delivery date.

Steve Hairston, Chief of Operations Support, DMH, addressed service gaps and the Long Term Plan for meeting MHDDSA service needs and reported that a final report would be submitted June 30, 2006.

Leza Wainwright, Deputy Director, DMH, gave an update on regional Utilization Review and Screening, Triage and Referral (UR/STR) with a brief overview of the application and evaluation process for selecting LMEs to perform UR functions. A review team determined that no LME met the required standards. This means the current Medicaid contractor doing UR for MHDDSA services and previously selected through an RFP process (Value Options) will perform all Medicaid UR functions with the exception of the five counties that comprise the Piedmont catchment area.

The review committee identified five LMEs to perform regional after hours STR. There were some partnerships where a program was not identified as having the capacity to perform the function. A decision as to how to perform the after hours STR in those catchment areas will be determined at a later date.

April 12, 2006

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services held its eighth meeting on Wednesday, April 12, 2006, at 1:30 P.M. in Room 643 of the Legislative Office Building.

Kory Goldsmith, Research Division, reviewed a packet of information that addressed committee member questions from the previous meeting. They included residency requirements by Medicaid; the use of target populations in other states; a chart showing contributions by each county to its LME; and questions regarding Utilization Review (UR) and Screening, Triage, and Referral (STR).

Representative Insko recognized two nationally known experts, Val Bradley with the Human Services Research Institute and Steve Day from Technical Assistance Collaborative, to present an outline of qualitative measures that the federal government and states like North Carolina are utilizing to measure system success. North Carolina already collects most of the data mentioned in the various domains to be measured – data in claims files; demographic information in the client data warehouse; consumer outcomes indicators; quarterly and annual reports from the LMEs; and the National Core Indicators pilot project. Given that North Carolina has the data, what remains is the need to be open to an analysis of the data and opening up that data to interpretation among stakeholders.

Flo Stein, Chief of Community Policy Management, DMH, gave a brief overview of how the Division is gathering and using data and other indicators. Spencer Clark, Director of Operations and Clinical Services, DMH, gave an overview of reports that are currently produced to show the kind of data in existence and how it might be presented.

Kory Goldsmith, Research Division, presented the draft findings and recommendations of the LOC. The findings and recommendations addressed: building community capacity and financing reform, facility-based and non-facility based crisis services; the Department of Health and Human Services and the Division of MH/DD/SAS.

Senator Nesbitt, Co-Chair, asked members to review the document and to make changes or recommendations so staff could revise the report in time for the next meeting. He said the total amount of the proposal was $104,598,000in recurring funds and $55,000,000 in non-recurring funds. Senator Malone suggested that a statement be included in the narrative recognizing that the Department had not been given adequate funding to make system reform succeed. Senator Nesbitt added that there had also been a recession that created additional problems.

April 27, 2006

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Thursday, April 27, 2006, at 1:30 P.M. in Room 544 of the Legislative Office Building.

Representative Insko, Co-Chair, said that many comments had been received and incorporated into the revised proposals and others received were under consideration. She also said that the proposals would be in bill form to be approved at the next meeting on May 10th.

Kory Goldsmith, Research Division, and Andrea Russo, Fiscal Research, reviewed the revised proposals.

Members suggested adding a provision to the report stating that any savings realized from financing the 400 independent and supportive living apartments be used to assist the *Healing Place* and others similar establishments

Representative Insko then asked members of the public who had signed-up prior to the meeting to come forward and provide the Committee with their thoughts on the proposals. Those addressing the Committee were: David Swann, Mike Watson, Mary Short, Martha Brock, Jay Zamagoca, Robin Huffman, Chris Estes, Laurie Coker, Dave Richard, Will Callison, Sally Cameron, Louise Fisher, Paula Cox Fishman, Carol Matthew, Mark Botts, Margaret Weller-Stargell, and Nancy Carey.

Senator Nesbitt, Co-Chair, suggested that the Committee add a paragraph to the report to increase insurance coverage for mental health and to move parity ahead. He also suggested adding a statement in the Introduction stating that this effort is a first step in the solution to reform and the LOC will continue to work and make recommendations to the General Assembly as it moves forward.

COMMITTEE FINDINGS AND LEGISLATIVE PROPOSALS

Introduction

In 2001, the General Assembly adopted significant reform legislation to restructure how services to those with mental illnesses, developmental disabilities and substance abuse issues would be delivered. The foundations of reform included: local management of the system, decreased reliance on State institutions, community based best practice treatments, increased consumer involvement, access to multiple and qualified providers, and performance and fiscal accountability to the State and local governments. As part of the legislation, the General Assembly directed the Secretary of DHHS ("Secretary") and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services ("Division") to undertake administering massive system reform. The reform has been overseen by the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC).

The reform effort never assumed that the system was adequately or fairly funded. It did attempt to shift resources from the State to the local level, to target services to those with the most severe disabilities, and to gain administrative efficiencies and economies of scale through consolidation. In 2001, the General Assembly created the Mental Health Trust Fund and made a significant appropriation of $50 million to assist reform. However, reform has taken place during a time of significant budget shortfalls and intervening events have severally diminished both the size of the Trust Fund and the State's ability to make up the

shortfalls. As a result, during the five years of implementation, the State has not fully funded existing programs nor provided sufficient funds to build service capacity at the local level. LOC staff has estimated that it would cost $172,585,338 to bring the current level of services to all who are eligible and who would also seek services. This figure does not take into account any increase in the array or availability of services. Other estimates of the State's need range from an additional $475 million to fully fund substance abuse services over 5 years and $285 million to bring North Carolina's per capita spending for mental health services to near the national average.

In recognition of these shortcomings, the LOC makes the findings and proposals on the following pages. The total appropriations recommended herein are $156,323,769. Of that, just over $100 million are recurring funds and $56.3 million are non-recurring. The LOC recognizes that additional funds will need to be appropriated in the future to fully implement a mental health, developmental disabilities, and substance abuse system. However, the proposals in this report constitute a bold step forward. The LOC believes this is an appropriate amount of new funding at this point in time and that it will move the system significantly towards its goals.

1. State Funding for MH/DD/SA Services and Funding Allocations

The total (state and federal) actual expenditures for FY04/05 for the mental health, developmental disabilities, and substance abuse system (MH/DD/SA) were $1,102,393,603.[1] Of those funds, 52% or $575,965,746 paid for the State institutions and 3% or $36,597,727 paid for administration. The remaining 44% or $489,830,130 was used to pay for community programs. Of the total funds appropriated by the State, $580,479,364 (or 53%) were state funds.

[1] This amount does not include Medicaid funds flowing to the community or directly to providers.

In FY2005, the average State funds expended per person served with a developmental disability were $10,192. The average State funds expended per person served with a mental illness were $1,001. The average State funds expended per person served with a substance abuse diagnosis were $1,028. During FY2005, the State paid a total of $124,951,834 in claims for developmental disability services, $87,037,667 in claims for mental health services, and $28,702,300 for substance abuse services.

According to "The State of the States in Developmental Disabilities: 2005" by the Department of Psychiatry and Coleman Institute for Cognitive Disabilities at the University of Colorado, North Carolina ranks 26th in "fiscal effort"[2] in total spending for MR/DD services. Applying this same measure for mental health services and substance abuse services, North Carolina ranked 44th in fiscal effort for mental health services and 17th in fiscal effort for substance abuse services[3]. According to a report issued by the North Carolina Psychiatric Association, it would cost an additional $285,500,000 to bring North Carolina's per capita spending on mental health services to 88.8% of the national per capita spending in FY2002-2003.[4] According to the 2001 report to the LOC by MGT of America[5], the estimated cost of implementing a complete substance abuse system in North Carolina over a 5-year period would require an additional $71,000,000 funding in FY 2003,

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[2] In this report, "fiscal effort" is defined as spending for services per $1,000 of aggregate statewide personal income.

[3] For mental health services "fiscal effort", staff used the data from National Alliance on Mental Illness. Grading the States: A Report on America's Health Care system for Serious Mental Illness, published March 1, 2006. For substance abuse services, staff used statewide substance abuse spending data obtained from SAMHSA and population and income figures from the 2000 Census.

[4] The 88.8% figure represents North Carolina's average income in relationship to the national average income.

[5] MGT of America. Study of Mental Health/Substance Abuse Facilities and Their Role in North Carolina's System of Care, Final Report to the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, October 2001.

$74,000,000 for FYs 2004 and 2005, and an additional $127,000,000 in FYs 2006 and 2007. According to information provided to the LOC by committee staff, the estimated State funds that would be needed to serve the estimated target populations who are not Medicaid eligible and who would seek public services would be $172,585,338.[6] This amount represents what it would cost to serve more consumers based on current State spending per consumer.

Unlike Medicaid, access to State-funded services is not an entitlement. It is the primary source for indigent care and for services not covered by Medicaid. State funding for services has remained stagnant since 2001. There have been small, isolated budget increases mixed with budget reductions. There have been no inflationary increases. During this same time period, North Carolina's population has increased by an estimated 7%.

Due to changes in federal policy, the service known as Developmental Therapies will no longer be a Medicaid reimbursable service when provided to developmentally disabled individuals. Because of this change, the Division has submitted, and it is the LOC's understanding that the Governor's Budget will include, a request for $29,435,119 in recurring funds to cover the service. While the LOC does not oppose this request, if funded, it will have the effect of further exacerbating the disparity between the State expenditures for disability groups.

Most of the State appropriations are divided into disability and age categories, and the units of local government that administer and manage the MH/DD/SA system (LMEs) are restricted from shifting funds between disabilities. LMEs report having difficulty spending down certain funds, especially related to substance abuse services.

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[6] Fiscal Research Division, Budget Overview of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, March 2006.

There is no equitable or rational allocation of State funds between LMEs. Excluding Cross Area Service Program funding, the highest SFY 2005-2006 State Service Dollar allocation per capita of catchment area is $48.18, and the lowest is $21.80. The State allocation per capita is $34.15. The median State service dollar per capita is $37.65. Although the reform legislation of 2001 recognized the need to address this situation, to date, neither the LOC nor the Division have developed any recommendations.

2. Building Community Capacity/Financing Reform

In 1999, the United State Supreme Court held in Olmstead v. L.C. and E.W. that states have an obligation to provide community-based treatment for persons with mental disabilities. In 2001, the General Assembly created the Mental Health Trust Fund (Trust Fund, G.S. 143-15.3D) and appropriated $50 million to it. In that same year, the Governor used his emergency powers to transfer $37.5 million from the Trust Fund due to the budget crisis. Although the General Assembly has appropriated over $30 million to the Trust Fund since 2001, those amounts have not been sufficient to replace what was lost and have not been sufficient to successfully implement system reform.

The LOC recognizes that affordable and appropriate housing is a critical element of a community's capacity to successfully transition MH/DD/SAS consumers from institutions to the community. There are not sufficient affordable and appropriate housing resources for MH/DD/SAS consumers in this State and that situation significantly impedes the State's ability to comply with Olmstead.

G.S. 143-15.3D(b) provides that the purposes for which the funds in the Trust Fund may be used are:

(1) Start-up and operating support for cost-effective community treatment alternatives for individuals currently residing in the State's mental health, developmental disabilities, and substance abuse services institutions.

(2) Facilitate the State's compliance with the United States Supreme Court decision in Olmstead v. L.C. and E.W.

(3) Facilitate reform of the mental health, developmental disabilities, and substance abuse services system and expand and enhance treatment and prevention services in these program areas to remove waiting lists and provide appropriate and safe services for clients.

(4) Provide bridge funding to maintain appropriate client services during transitional periods as a result of facility closings.

(5) Construct, repair, and renovate State mental health, developmental disabilities, and substance abuse services facilities.

The 2001, 2003, and 2005 budgets provide that recurring savings realized from downsizing of the of State psychiatric hospitals would be retained by DHHS for implementation of the hospital downsizing and to support the recurring costs of additional community-based placements. In 2003, the General Assembly passed the Psychiatric Hospital Financing Act (S.L. 2003-314). It provided that the new psychiatric hospital would be financed through certificates of participation. It also amended the Mental Health Trust Fund to provide that recurring savings realized from the closure of any State psychiatric hospitals would not revert to the General Fund but would be used for the payment of debt service for the construction of a new State psychiatric hospital. Any remainder not needed for the debt service was to be credited to the Department of Health and Human Services to be used only for compliance with the Olmstead decision and to facilitate mental health reform. The provisions regarding the use of recurring savings from hospital downsizing

contained in the 2005 Budget and in the Psychiatric Hospital Financing Act appear to be inconsistent.

Downsizing of the State psychiatric hospitals has slowed substantially in the last few years due to the lack of community capacity to successfully place MH/DD/SAS consumers in the community. The estimated debt service on new psychiatric hospital for State fiscal year 2006-2007 will be $6,206,680. To date, the Division has realized $3.4 million dollars in recurring savings from downsizing the Dorothea Dix and John Umstead psychiatric hospitals that can be used to offset the projected debt service in FY 06-07 and thereafter. There are not sufficient savings being realized from downsizing to meet fully the debt service cost, and there are no excess funds to shift to community programs.

The apparent inconsistency regarding the use of recurring savings from downsizing combined with the delay in realized savings from downsizing impedes the State's ability to comply with Olmstead and implement system reform.

According to a collaborative project published by the North Carolina Health Education Centers (NC AHEC), the Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, and the Cecil G. Sheps Center for Health Service Research, UNC-CH,[7] North Carolina ranks 20th in the nation in psychiatrists per 10,000 population but due to the state's rapid populations increases, that situation is expected to worsen in the coming years. In addition, forty-four counties have a shortage of general psychiatrists, and 43 counties have no child psychiatrists. Also, due to the slow growth in the supply of psychiatrists, public mental health provider groups and especially rural provider groups face stiff competition in recruiting and retaining psychiatrists to their practices. According to

[7] "The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform, January 2006.

a report published by the National Conference of State Legislators[8] almost one in five children in the U.S. has a diagnosable mental disorder, but only about 20 to 25% of those children receive treatment. The gap in treatment is attributed in part to the lack of child and adolescent psychiatrists. Some states are addressing these issues by expanding the used of telemedicine practices to serve children in rural areas. Congress is considering establishing education incentives to recruit child psychiatry residency programs with and estimated cost of $45 million for FY 2006 to 2007.[9]

3. Facility-based and Non-Facility based Crisis Services

G.S. 122C-2 provides that, within available resources, State and local government shall ensure that certain "core services", including emergency services, are available to all persons in this State. G.S. 122C- 115.2(b)(1)h. requires area authorities and county programs to develop a business plan that ensures access to core services, including crisis services. G.S. 122C-117(a)(14) provides that crisis services do not require prior authorization, shall be designed for prevention, intervention and resolution, do not consist solely of triage and transfer, and shall be provided in the least restrictive setting possible consistent with individual and family needs and community safety.

Appropriate crisis services are not consistently available across the State. There are not a sufficient number of community hospital psychiatric beds to meet local needs. At least three catchment areas have no community hospital psychiatric beds available. At least four catchment areas have no facility-based crisis services available, and those facilities that are available frequently serve limited populations.

[8] "Child Psychiatrist Shortage Looms", Michelle Herman, March 2006.
[9] The Child Health Care Crisis Relief Act (H.R. 1106/S 537).

Certain crisis services, especially those that are facility-based, must serve large regions in order to be cost effective.

Area authorities and county programs do not have sufficient "start-up" funds to develop and establish new crisis services. There are inadequate State funds to pay for crisis services to the non-Medicaid eligible population.

Certain crisis services must be available at all times regardless of whether the service is being utilized at any particular time. However, the fee for service structure makes it difficult for area authorities and county programs to ensure that necessary professionals will be accessible at all times. It is not clear whether the approved rate for psychiatrists will be sufficient to assure that those services will be available on a continuous basis.

4. Department of Health and Human Services/Division of MH/DD/SAS

In 2001, the General Assembly directed the Secretary of DHHS and the Division of MH/DD/SAS to undertake administering massive system reform. This reform has taken place during a time of budget crisis and changing federal requirements. While recognizing that this undertaking has been extremely challenging, that the State has not fully funded the system, and that the task is not finished; in order to be successful, the Secretary and the Division must demonstrate strong leadership and vision in the future.

The State Plan has been reissued each year but has not functioned as the strategic planning document that the General Assembly requested. In particular, it is not clear whether the plans are cumulative or supersede each other, which tasks have been accomplished and which are left to be done, and whether system reform is improving services to consumers.

The Secretary has failed to adopt rules as directed under G.S. 122C-112.1, failed to utilize her authority when approving business plans to move area

authorities and county programs towards greater administrative efficiencies, and has implemented policy in a manner that produced distrust among stakeholders and threatened to further destabilize a fragile system.

The Division has allowed the time-lines for State and local implementation to become disconnected, has failed to provide sufficient technical assistance to LMEs, and has been reluctant to impose "State-wideness" in situations where uniform standards have been necessary.

5. Local Management Entities (LMEs)

The role of local MH/DD/SAS programs changed significantly under system reform from that of a service provider to a manager of services. As a result, local programs may only provide services if they receive a waiver from the Secretary. The managerial powers and duties of local programs are not as clearly defined and must be inferred from the statutory requirements of the local business plan.

The responsibility of LMEs to conduct utilization review (UR) for Medicaid services is not clearly articulated in Chapter 122C. It appears that LMEs were expected to develop that capacity because the LME cost model includes funding for this function, the Division solicited applications from LMEs to receive approval to implement that function, and the 2005 RFP for a State-wide Medicaid UR vender provided that between 2 and 6 LMEs were expected to receive authorization to conduct UR during the contract period. Despite these expectations, the Secretary has determined that all Medicaid UR will be conducted by a state-wide vendor for at least the next three years. While the LOC recognizes the Secretary's obligation under Medicaid to ensure "State-wideness", it finds that the process she undertook to implement this significantly undermined the stability of the public system. The LOC also finds that by removing this function from the public sector, the Secretary

may significantly undermine the ability of LMEs to manage services in their catchment areas. In light of these changes, the LOC finds that utilization review for State-funded services and screening, triage and referral of all crisis calls are necessary components to the management role of local programs.

In 2001, the General Assembly directed the Secretary to develop a plan to accomplish the consolidation of area authorities so that by January 1, 2007, there would be 20 total programs. While Chapter 122C does specifically mandate consolidation, the General Assembly's intent was clear. The Secretary did not utilize her statutory authority to achieve consolidation through the approval of local business plans and there are currently 29 LMEs. According to the Secretary's report to the General Assembly, there are very few additional mergers to be realized. The LOC finds that additional consolidations are necessary to accomplish system reform.

In 2001, the General Assembly recognized that competent management was critical to the success of system reform. It amended G.S. 122C-121(d) to provide that area programs directors must have a master's degree, and have related and managerial experience. The LOC finds that the success of an area program is largely dependent upon the ability of the director to understand and implement system reform. It also finds that the current statutory qualifications are drawn very broadly and may not capture the necessary skills. The LOC also finds that the position of LME finance officer is critical to sound fiscal management, but there are no statutory requirements for that position.

G.S. 122C-119.1 requires all area board members to "receive initial orientation" on their responsibilities. It also requires DHHS to provide training in "fiscal management, budget development, and fiscal accountability". The LOC

finds that it is critical that board members receive this training and that there should be some mechanism to enforce this requirement.

6. Consumers

In 2001, the General Assembly recognized the importance of consumers in system reform. It directed that the State Plan provide for "consumer involvement in planning and management of system services". The State Plan directed that each LME establish a local Consumer and Family Advisory Committee (CFAC) and charged the CFACs with participating in and commenting on the LMEs business plans and operating budgets. The State Plan also created the State CFAC, whose members are appointed by the Secretary.

The LOC finds that it is important to focus and formalize the advisory role of consumers in system reform. It also finds that representation on the State CFAC should be broadened to include appointments by other stakeholders.

7. Providers

Providers are one of the major components in system reform and service delivery. The success of reform depends in large part upon a provider system in which high quality services are available in sufficient quantity to meet the identified needs of consumers. However, at the same time that the public system has needed more and better providers to deliver services, a variety of circumstances have made it very difficult for both established and newly created providers to survive financially.

LMEs have adopted differing provider contracts and required differing levels of utilization control. There has not been a uniform definition of what constitutes a *clean claim*, resulting in confusion in what is required for billing and delays in payments. Providers also report excessive and unnecessary paperwork in order to obtain authorization to provide services.

System reform also requires providers to implement new services based upon evidence based-practices. Utilization of these best practices will result in better services to consumers, and will be a better use of public funds because the services have been shown to be more effective.

The Division has developed a Provider Action Agenda to address many of these issues. The authority of the Division to implement uniform processes and procedures should be clarified.

8. Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services was created in 2000 to develop a plan for reform of the MH/DD/SA system. The committee and its multiple subcommittees met repeatedly during the interim and into the Regular Session of the 2001 General Assembly. The resulting legislation (HB 381, S.L. 2001-437) significantly restructured the system and put in place the framework of reform. The foundations of reform include: local management of the system, decreased reliance on State institutions, community based best practice treatments, increased consumer involvement, access to multiple and qualified providers, and performance and fiscal accountability to the State and local governments.

The LOC is charged with examining on a continuing basis system-wide issues affecting the development, financing, administration, and delivery of MH/DD/SA services. It is also charged with studying the budget, programs, administrative organization, and policies of DHHS to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided in North Carolina. In this capacity, the LOC has replaced the Legislative Study Commission on Mental

Health, Developmental Disabilities, and Substance Abuse Services (Commission) as the legislative entity monitoring the MH/DD/SA system. All reports previously submitted to the Commission now come to the LOC, and the Commission has been inactive since passage of the reform legislation.

9. Increased Insurance Coverage

The LOC recommends that private and public insurance providers increase the amount of coverage they offer their members, and that the coverage include treatment for mental illness and substance abuse.

Conclusion

The Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services makes the following eight recommendations to the 2006 Regular Session of the 2005 General Assembly. Each proposal is followed by a bill summary and, if it has a fiscal impact, a fiscal memorandum indicating any anticipated revenue gain or loss resulting from the proposal.

1. Increase State funding for MH/DD/SA Services
2. MH/DD/SA Community Capacity/Financing Reform
3. Increase MH/DD/SA Crisis Services
4. Strengthen State MH/DD/SA Reform
5. Strengthen LMEs
6. Consumer and Family Advisory Committees
7. Strengthen MH/DD/SA Private Providers
8. Strengthen LOC Oversight Role
9. Increased Insurance Coverage

LEGISLATIVE PROPOSAL #1

INCREASE STATE FUNDING FOR MH/DD/SA SERVICES

LEGISLATIVE PROPOSAL #1:

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS
TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

AN ACT TO INCREASE STATE FUNDING AND FLEXIBILITY FOR MH/DD/SA SERVICES.

SHORT TITLE: **Increase State funding for MH/DD/SA Services**

SPONSORS:

BRIEF OVERVIEW: This bill would:

1. Appropriate $72,888,259 (recurring) to be used for state-funded services to be allocated as follows:
   a. $29,435,119 for Development Therapy services for the developmentally disabled.
   b. $21,726,070 to be used for State funded mental health services.
   c. $21,726,070 to be used for State funded substance abuse services.
   d. The funds allocated for mental health and substance abuse services would be allocated to those LMEs whose current state service dollar allocation per capita is less than the median State service dollar per capita allocation ($37.65) based on the SFY 05-06 allocations.
2. Allow LMEs the flexibility to shift up to 15% of their funds between age and disability categories.

EFFECTIVE DATE: This bill would become effective July 1, 2006.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-RCz-23 [v.7] (04/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/9/2006 3:56:54 PM

Short Title:	Increase State funding for MH/DD/SA Services. (Public)
Sponsors:	.
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO INCREASE STATE FUNDING AND FLEXIBILITY FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of seventy-two million eight hundred eighty-eight thousand two hundred fifty-nine dollars ($72,888,259) for the 2006-2007 fiscal year that to be allocated as follows:

1. $29,435,119 to pay for developmental therapies for the developmentally disabled. The Division shall develop rigorous care management requirements for this service.
2. $21,726,070 to pay for mental health services.
3. $21,726,070 to pay for substance abuse services.
4. The funds allocated under subsections (2) and (3) of this section shall be allocated to those area authorities and county programs where the current state service dollar allocation per capita is less than the median state service dollar per capita allocation, which is $37.65 based upon the State fiscal year 2005-2006 allocations.

SECTION 2. G.S. 122C-147.1 is amended by adding a new subsection to read::

"(a) Notwithstanding G.S. 143-23, an area authority or a county program may transfer from one age or disability category to a different age or disability category up to fifteen percent (15%) of the funds initially allocated to the age or disability category from which funds are being transferred. Area authorities and county programs must

demonstrate that they have addressed the service needs of the category from which the funds are being transferred before any transfer may occur."

SECTION 3. This act becomes effective July 1, 2006. The Fiscal Research Division shall track the allocation and utilization of the funds appropriated under this act.

LEGISLATIVE PROPOSAL #2

MH/DD/SA COMMUNITY CAPACITY/FINANCING REFORM

LEGISLATIVE PROPOSAL #2:

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS
TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

AN ACT TO APPROPRIATE FUNDS TO INCREASE INDEPENDENT AND SUPPORTIVE LIVING APARTMENTS FOR PERSONS WITH MH/DD/SA DISABILITIES; TO REVISE THE PSYCHIATRIC HOSPITAL FINANCING ACT; TO CREATE INCENTIVES FOR PSYCHIATRISTS TO WORK IN UNDERSERVED COMMUNITIES; AND TO APPROPRIATE FUNDS TO THE MENTAL HEALTH TRUST FUND.

SHORT TITLE: **MH/DD/SA Community Capacity/Financing Reform**

SPONSORS:

BRIEF OVERVIEW: This bill would:

1. Finance 400 independent- and supportive-living apartments for individuals with MH/DD/SA disabilities.
   a. Appropriate $12,050,830 (non-recurring) to provide an operating cost subsidy for the apartments for 10 years.
   b. Appropriate $11,250,000 (non-recurring) to the North Carolina Housing Trust fund to finance the apartments.
2. Appropriate $713,000 (recurring) for on-going operations support and $370,000 for start-up expenses (non-recurring) to support 12 group home beds and 93 apartments financed through the United States Department of Housing and Urban Development .
3. Appropriate $20,000,000 (non-recurring) to the Mental Health Trust Fund.
4. Appropriate $6,206,680 (recurring) for hospital debt service and reconcile the provisions of the Psychiatric Hospital Financing Act and the 2005 Budget so that debt service is paid from appropriations and savings from downsizing are used for building community capacity.
5. Appropriate $1,000,000 (recurring) to AHEC/Rural Health Program to develop a program, which may include loan repayment, to recruit psychiatrists to rural and underserved areas to provide community services.

EFFECTIVE DATE: The bill would become effective July 1, 2006.

A copy of the proposed legislation and fiscal memorandum begin on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-RCz-22 [v.9] (04/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/9/2006 2:09:35 PM

Short Title:	MH/DD/SA Community Capacity/Financing Reform.	(Public)
Sponsors:	(By Request).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO INCREASE INDEPENDENT AND SUPPORTIVE LIVING APARTMENTS FOR PERSONS WITH MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE ADDICTIONS, TO REVISE THE PSYCHIATRIC HOSPITAL FINANCING ACT, TO CREATE INCENTIVES FOR PSYCHIATRISTS TO WORK IN UNDERSERVED COMMUNITIES, AND TO APPROPRIATE FUNDS TO THE MENTAL HEALTH TRUST FUND AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

PART I. HOUSING

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of twelve million fifty thousand eight hundred thirty dollars ($12,050,830) for the 2006-2007 fiscal year to be placed in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs. The Department shall work with the North Carolina Housing Finance Agency to use the funds to provide an operating cost subsidy for at least four hundred (400) independent and supportive living apartments for individuals with mental illness, development disabilities, and substance abuse addictions. The apartments shall be affordable to those with incomes at the Supplemental Security Income (SSI) level.

SECTION 2. There is appropriated from the General Fund to the North Carolina Housing Finance Agency (HFA) the sum of eleven million two hundred fifty thousand dollars ($11,250,000) for the 2006-2007 fiscal year to be placed in the North Carolina Housing Trust Fund. The funds shall be used to finance the construction of at least four hundred (400) independent and supportive living apartments for individuals

with mental illness, development disabilities, and substance abuse addictions. whose incomes are at the Social Security level. The apartments shall be affordable to those with incomes at the Supplemental Security Income (SSI) level. If HFA is able to finance the apartments for less than the amount appropriated under this Section, any remaining funds as well as any interest earned on the amount appropriated may be used to finance additional apartment, group homes, and transitional housing for individuals with mental illness, development disabilities, and substance abuse addictions.

SECTION 3. There is appropriated from the General Fund to the Department of Health and Human Services for the 2006-2007 fiscal year the sum of seven hundred thirteen thousand dollars ($713,000) for on-going operations support and three hundred seventy thousand dollars ($370,000) for start-up expenses to be placed in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs to support 12 group home beds and 93 apartments financed through the United States Department of Housing and Urban Development

PART II. MENTAL HEALTH TRUST FUND

SECTION 4. There is appropriated from the General Fund to the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs the sum of twenty million dollars ($20,000,000) for the 2006-2007 fiscal year.

SECTION 5. Section 10.24.(b) of S.L. 2005-276 reads as rewritten:

"**SECTION 10.24.(b)** The Department shall use not less than fifty percent (50%) of moneys in the Trust Fund established pursuant to G.S. 143-15D for the ~~2005-2006~~ 2006-2007 fiscal year for nonrecurring start-up funds for community-based services, including funding for existing area program services to transition to the private sector or to another public service agency. Moneys in the Trust Fund may be used to expand recurring community-based services only if sufficient recurring funds can be identified within the Department from funds currently budgeted for mental health, developmental disabilities, and substance abuse services, area mental health programs or county programs, or local government."

PART III. PSYCHIATRIC HOSPITAL DEBT SERVICE

SECTION 6. G.S. 143-15.3D(c) reads as rewritten:

"(c) Notwithstanding G.S. 143-18, any nonrecurring savings in State appropriations realized from the closure of any State psychiatric hospitals that are in excess of the cost of operating and maintaining a new State psychiatric hospital shall not revert to the General Fund but shall be placed in the Trust Fund and shall be used for the purposes authorized in this section. Notwithstanding G.S. 143-18, recurring savings realized from the closure of any State psychiatric hospitals shall not revert to the General Fund but shall be ~~used for the payment of debt service on financing contract indebtedness authorized pursuant to Article 9 of Chapter 142 of the General Statutes for the construction of a new State psychiatric hospital. Any remainder not needed for this debt service shall be~~ credited to the Department of Health and Human Services to be used only for the purposes of subsections (b)(2) and (b)(3) of this section."

SECTION 7. There is appropriated from the General Fund to the Reserve for Debt Service the sum of six million two hundred six thousand six hundred eighty

dollars ($6,206,680) for the 2006-2007 fiscal year. The funds shall be used to pay the debt service incurred by the financing of the new psychiatric hospital to replace the Dorothea Dix and John Umstead State psychiatric hospitals. It is the intend of the General Assembly to use funds from the General Fund to pay the debt service on the new psychiatric hospital. The Department of Health and Human Services shall redirect any funds previously budgeted for debt service on the new psychiatric hospital to the purposes authorized under G.S. 143-15.3D(b)(2) and (b)(3).

PART IV. RECRUITING AND RETAINING COMMUNITY PSYCHIATRISTS

SECTION 8. There is appropriated from the General Fund to the Board of Governors of The University of North Carolina for the 2006-2007 fiscal year the sum of one million dollars ($1,000,000) to be allocated to the UNC-CH Area Health Education Centers (AHEC) program. AHEC shall use the funds to develop and implement a program to recruit psychiatrists to rural and underserved areas to provide community services. The program may include student loan repayment.

SECTION 9. This act becomes effective July 1, 2006. The Fiscal Research Division shall track the allocation and utilization of these funds appropriated under this act.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2005

FISCAL ANALYSIS MEMORANDUM

[This confidential fiscal memorandum is a fiscal analysis of a draft bill, amendment, committee substitute, or conference committee report that has not been formally introduced or adopted on the chamber floor or in committee. This is not an official fiscal note. If upon introduction of the bill you determine that a formal fiscal note is needed, please make a fiscal note request to the Fiscal Research Division, and one will be provided under the rules of the House and the Senate.]

DATE: May 9, 2006

TO: Representative Insko and Senator Nesbitt

FROM: Jennifer Hoffmann
Fiscal Research Division

RE: 2005-RCz-22 [v.10]

FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available ( )**

	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
REVENUES:					
EXPENDITURES:					
General Fund (GF)					
DHHS Trust Fund for MH/DD/SA	**32,050,830**				
Division of MH/DD/SA	**1,083,000**	**713,000**	**713,000**	**713,000**	**713,000**
NCHFA Housing Trust Fund	**11,250,000**				
Reserve for Debt Service	**6,206,680**	**8,982,355**	**8,980,433**	**8,982,269**	**8,980,401**
University of NC AHEC	**1,000,000**	**1,000,000**	**1,000,000**	**1,000,000**	**1,000,000**
GF TOTAL	**51,590,510**	**10,695,355**	**10,693,433**	**10,695,269**	**10,693,401**
POSITIONS (cumulative):					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Service, Division of Mental Health, Developmental Disabilities, and Substance Abuse; NC Housing Finance Agency; UNC, Area Health Education Centers; Trust Fund MH/DD/SA and Bridge Funding Needs; Reserve for Debt Service

EFFECTIVE DATE: July 1, 2006

BILL SUMMARY:
Section 1 appropriates $12,050,830 on a non-recurring basis from the General Fund to the Department of Health and Human Services to be placed in the Trust Fund for Mental Health, Developmental Disabilities and Substance Abuse Services and Bridge Funding Needs (Trust Fund for MH/SDD/SA) to provide an operating cost subsidy for independent and supportive living apartments.
Section 2 appropriates $11,250,000 on a non-recurring basis from the General Fund to the Housing Finance Agency to be placed in the North Carolina Housing Trust Fund to finance the construction of independent and supportive living apartments.
Section 3 appropriates from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse the following: $713,000 for on-going operations support and $370,000 for start-up expenses to support 12 group home beds and 93 apartments financed through the United States Department of Housing and Urban Development.
Section 4 appropriates $20,000,000 on a non-recurring basis from the General Fund to the Trust Fund for MH/DD/SA for the uses set out in the Trust Fund statute.
Section 6 rewrites a section of the Trust Fund for MH/DD/SA (G.S. 143-15.3D(c)) by deleting the directive that the recurring savings realized from the closure of any State psychiatric hospital shall be used to repay the debt service incurred for the construction of the new State psychiatric hospital. Clarifies that the recurring savings shall be credited to the Department of Health and Human Services for community-based services.
Section 7 appropriates $6,206,680 from the General Fund to the Reserve for Debt Service in FY 2006-07 for the debt service associated with the construction of the new psychiatric hospital. States the intent of the General Assembly to appropriate funds from the General Fund for the debt service until the debt is fully paid. Also, directs the Department of Health and Human Service to move funds currently budgeted for the debt service to community-based services.
Section 8 appropriates $1,000,000 on a recurring basis from the General Fund to the University of North Carolina to be allocated to the Area Health Education Centers (AHEC) to develop and implement a program to recruit psychiatrists to rural and underserved areas to provide community services.

ASSUMPTIONS AND METHODOLOGY: The fiscal impact of the sections that contain a direct appropriation is the amount of the appropriation (see table on page 1). Sections 1, 2, 3 and 4 all contain non-recurring appropriations that affect the 2006-07 fiscal year only. Sections 3 and 8 contain recurring appropriations that affect all future General Fund budgets unless the General Assembly takes action to remove these items from the budget. Section 7 also contains a recurring appropriation for the repayment of debt service associated with the construction of the new psychiatric hospital. The exact amount of the annual debt service varies in accordance with the debt service schedule and shall continue until the last debt service payment is made in 2027. The 2006 COPS issuance is scheduled for the fall and debt service was calculated using a projected interest rate of 5.75%.

According to the Office of the State Treasurer, actual and estimated debt service costs for the new psychiatric hospital follow on page 3:

Psychiatric Hospital Debt Service Schedule			
Authorized COPS Issuance by Year	**57,207,490**	**48,961,672**	**106,169,162**
State Fiscal Year	**2005 Issuance Actual Debt Service Payments**	**2006 Issuance Est'd Debt Service Payments**	**Total Debt Service Payments**
2005	0	0	0
2006	3,782,471	0	3,782,471
2007	4,799,032	1,407,648	6,206,680
2008	4,799,586	4,182,769	8,982,355
2009	4,798,311	4,182,122	8,980,433
2010	4,799,708	4,182,561	8,982,269
2011	4,798,493	4,181,908	8,980,401
2012	4,800,543	4,182,737	8,983,280
2013	4,799,328	4,181,888	8,981,216
2014	4,799,252	4,182,860	8,982,112
2015	4,798,417	4,182,442	8,980,859
2016	4,799,556	4,182,224	8,981,780
2017	4,799,177	4,182,760	8,981,937
2018	4,800,012	4,182,695	8,982,707
2019	4,798,569	4,182,584	8,981,153
2020	4,799,101	4,182,927	8,982,028
2021	3,795,916	4,182,317	7,978,233
2022	3,644,079	4,182,182	7,826,261
2023	3,492,243	4,182,918	7,675,161
2024	3,340,406	4,182,080	7,522,486
2025	3,188,569	4,182,902	7,371,471
2026	0	4,182,832	4,182,832
2027		4,182,212	4,182,212
Total Debt Service per Issuance	**88,432,770**	**85,057,568**	**169,707,868**

SOURCES OF DATA: Office of State Treasurer

TECHNICAL CONSIDERATIONS: None

LEGISLATIVE PROPOSAL #3

INCREASE MH/DD/SA CRISIS SERVICES

LEGISLATIVE PROPOSAL #3:

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS
TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

AN ACT TO APPROPRIATE FUNDS FOR START-UP CRISIS SERVICES, TO HIRE A CONSULTANT TO ASSIST AREA AUTHORITIES DEVELOP AND IMPLEMENT CRISIS SERVICES, TO INCREASE FUNDING TO PAY FOR CRISIS SERVICES, TO ENSURE ACCESS TO CORE PSYCHIATRIC SERVICES, AND TO EXTEND THE SUNSET ON THE FIRST COMMITMENT PILOT PROGRAM.

SHORT TITLE: **Increase MH/DD/SA Crisis Services.**

SPONSORS:

BRIEF OVERVIEW: This bill would:

1. Appropriate $10,500,000 (non-recurring) to be used by LMEs to establish a continuum of crisis facilities regionally and crisis services locally. It would also appropriate $425,000 (non-recurring) for the General Assembly to hire a consultant to assist LMEs with developing and implementing start-up crisis services.
2. Appropriate $9,000,000 (recurring) to create a fund to be used by LMEs to pay for non-Medicaid reimbursable crisis (core) services.
3. Appropriate $9,000,000 (recurring) for LMEs to ensure access to core psychiatrist services.
4. Extend the sunset for the First Commitment Pilot Program from July 1, 2006 to October 1, 2007.

EFFECTIVE DATE: This bill would become effective July 1, 2006.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

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BILL DRAFT 2005-RCz-24 [v.6] (04/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/9/2006 11:55:42 AM

Short Title: Increase MH/DD/SA Crisis Services.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR START-UP CRISIS SERVICES, TO HIRE A CONSULTANT TO ASSIST AREA AUTHORITIES AND COUNTY PROGRAMS DEVELOP AND IMPLEMENT A PLAN TO CREATE A CONTINUUM OF CRISIS SERVICES, TO PAY FOR CRISIS SERVICES FOR NON-MEDICAID ELIGIBLE INDIGENT INDIVIDUALS, TO ENSURE ACCESS TO CORE PSYCHIATRIC SERVICES, AND TO EXTEND THE SUNSET FOR THE FIRST COMMITMENT PILOT PROGRAM AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a). There is appropriated from the General Fund to the Department of Health and Human Services the sum of ten million five hundred thousand dollars ($10,500,000) for the 2006-2007 fiscal year. The funds shall be used by area authorities and county programs to establish a continuum of regional crisis facilities and local crisis services for persons with mental illness, developmental disabilities, and substance abuse addictions.

The area authorities and county programs will organize themselves into no more than twenty-one (21) crisis regions based upon the existing Geriatric Specialty team configurations or other approved regions. The funds shall be allocated to each area authority or county programs on a per capita basis. The funds may be used for operational start-up, capital, or subsidies related to developing a continuum of crisis services. No more than three percent (3%) may be spent for administrative costs. The area authorities and county programs within a crisis region shall work together to identify gaps in their ability to provide a continuum of crisis services for all consumers and use the funds appropriated to them to develop and implement a plan to address those needs. At a minimum, the plan must address the development over time of the

following components: 24-hour crisis telephone lines, walk-in crisis services, mobile crisis outreach, crisis respite/residential services, crisis stabilization units, 23-hour beds, facility-based crisis, in-patient crisis and transportation. Options for voluntary admissions to a secured facility must include at least one service appropriate to address the mental health, development disability, and substance abuse needs of adults and the mental health, development disability, and substance abuse needs of children. Options for involuntary commitment to a secured facility must include at least one option in addition to admission to a State facility.

If all area authorities and county programs in a crisis region determine that a facility-based crisis center is needed and sustainable on a long term basis, the crisis region shall attempt to secure those services through a community hospital or other community facility first. If all the area authorities and county programs in the crisis region determine the region's crisis needs are being met, the area authorities and county programs may use the funds to meet local crisis service needs.

Each area authority and county program and each crisis region will be required to utilize the technical assistance of a consultant under contract with the General Assembly to develop and implement its crisis services plan. The consultant shall assist area authorities and county programs and crisis regions to identify local and regional gaps in crisis services, identify options for providing services, implement new services, and maintain transparency and accountability for the use of funds. The crisis region or area authorities and county programs shall submit their crisis services plan to the consultant and to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division) for review and public comment. The crisis regions and area authorities and county programs shall consider the comments prior to submitting a final plan for implementation. Upon submission of a final plan to DHHS, each crisis region, area authority and county program will receive implementation funds. Funds not expended during the 2006-2007 fiscal year shall not revert.

Area authorities and county programs and crisis regions must report monthly to the consultant and to the Division regarding the use of the funds, whether there has been a reduction in the use of State psychiatric hospitals for acute admissions, and remaining gaps in local and regional crisis services. The consultant shall report regularly to the General Assembly, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services regarding each crisis region's and area authorities' and county programs' proposed and actual use of the funds.

SECTION 1.(b). There is appropriated from the General Fund to the Department of Health and Human Services the sum of nine million dollars ($9,000,000) for the 2006-2007 fiscal year. These funds shall be allocated to area authorities and county programs on a per capita basis. Area authorities and county programs may bill this fund to pay for mental health, developmental disabilities or substance abuse crisis services provided to non-Medicaid eligible adults and children who are indigent and have no other third-party payment source. Nothing in this section shall prohibit an area authority or county program from using other funds to provide crisis services, nor shall

it limit an area authority or county program's obligation under G.S. 122C-2(2) to provide emergency services.

SECTION 1.(c). There is appropriated from the General Fund to the Department of Health and Human Services the sum of nine million dollars ($9,000,000) for the 2006-2007 fiscal year. These funds shall be allocated to area authorities and county programs on a per capita basis. Area authorities and county programs may use these funds to maintain public access to community psychiatric services. The funds may be used on a unit cost reimbursement or non-unit cost reimbursement basis.

SECTION 2. S.L. 2003-178 reads as rewritten.

"SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services on or before July 1, 2006.

(4) The waiver granted by the Secretary under this section shall be in effect ~~for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.~~until October 1, 2007.

(5) The Secretary may grant a waiver under this section to up to five local management entities that have been designated as phase-one entities as of July 1, 2003.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The local management entity shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires ~~July 1, 2006.~~October 1, 2007."

SECTION 3. This act becomes effective July 1, 2006. The Fiscal Research Division shall track the allocation and utilization of the funds appropriated under this Act.

LEGISLATIVE PROPOSAL #4

STRENGTHEN STATE MH/DD/SA REFORM

LEGISLATIVE PROPOSAL #4:

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS
TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

AN ACT TO STRENGTHEN STATE LEADERSHIP FOR SYSTEM REFORM OF MH/DD/SA SERVICES AND TO APPROPRIATE FUNDS.

SHORT TITLE: **Strengthen State MH/DD/SA Reform**

SPONSORS:

BRIEF OVERVIEW: This bill would:

1. Direct DHHS to consolidate recent State Plans to produce a single document that meets the requirements of G.S 122C-102 and contains a cumulative statement of all still-applicable provisions of those plans, identify those directives contained in the Plan and other communications by the Division that must be adopted as an administrative rule in order to be enforceable, and to undertake to adopt those rules.
2. Clarify that the State Plan is a strategic document intended to provide a course of State and local action for a 3-year period of time, that contains specific goals for system reform, designates benchmarks for reaching those goals and identifies data that can be utilized to measure progress towards those goals, and is coordinated with the implementation of crisis services by LMEs.
3. Clarify that the Secretary and the Division of MH/DD/SAS have a duty to provide more technical assistance to LMEs.
4. Appropriate $1,700,000 to DHHS (non-recurring) to hire one or more consultants to:
    a. Assist with strategic planning.
    b. Increase the capacity of DHHS to implement system reform.
    c. Assist the Division to work with LMEs to:
        1. Develop and implement 5-10 critical performance indicators to be used to hold LMEs accountable for managing the MH/DD/SA system.
        2. Standardize the utilization management functions for non-Medicaid services.

3. Develop LME expertise to undertake utilization management for Medicaid services beginning July 1, 2007, but no later than July 1, 2009.

4. Develop standardized LME operating procedures.

5. Implement other LME management functions.

d. Provide technical assistance and oversight to providers and LMEs to ensure that best practices and new services are being delivered with fidelity to the model.

EFFECTIVE DATE: The bill would become effective July 1, 2006.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

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BILL DRAFT 2005-RCz-25 [v.6] (04/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/9/2006 12:35:49 PM

Short Title:	Strengthen State MH/DD/SA Reform.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO STRENGTHEN STATE LEADERSHIP FOR SYSTEM REFORM OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES AND TO APPROPRIATE FUNDS AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a). G.S. 122C-102 reads as rewritten:

"**§ 122C-102. State Plan for Mental Health, Developmental Disabilities, and Substance Abuse ~~Services.~~Services; system performance measures.**

(a) Purpose of State Plan. – The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three-years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities and county programs over a three year period of time and benchmarks for determining whether progress is being made towards those goals. It shall also identify data that will be used to measure progress towards the specified goals. In order to increase the ability of the State, area authorities, county programs, private providers and consumers to successfully implement the goals of the State Plan, the Department shall not adopt or implement policies that are inconsistent with the State Plan without first consulting with the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Content of State Plan. – The State Plan shall include the following:

(1) Vision and mission of the State Mental Health, Developmental Disabilities, and Substance Abuse Services system.

~~(2) Organizational structure of the Department and the divisions of the Department responsible for managing and monitoring mental health, developmental disabilities, and substance abuse services.~~

(3) Protection of client rights and consumer involvement in planning and management of system services.

(4) Provision of services to targeted populations, including criteria for identifying targeted populations.

(5) Compliance with federal mandates in establishing service priorities in mental health, developmental disabilities, and substance abuse.

(6) Description of the core services that are available to all individuals in order to improve consumer access to mental health, developmental disabilities, and substance abuse services at the local level.

(7) Service standards for the mental health, developmental disabilities, and substance abuse services system.

(8) Implementation of the uniform portal process.

(9) Strategies and schedules for implementing the service plan, including consultation on Medicaid policy with area and county programs, qualified providers, and others as designated by the Secretary, intersystem collaboration, promotion of best practices, technical assistance, outcome-based monitoring, and evaluation.

(10) A plan for coordination of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services with the Medicaid State Plan, and NC Health Choice.

(11) A business plan to demonstrate efficient and effective resource management of the mental health, developmental disabilities, and substance abuse services system, including strategies for accountability for non-Medicaid and Medicaid services.

(12) Strategies and schedules for implementing a phased in plan to eliminate disparities in the allocation of State funding across county programs and area authorities by January 1, 2007, including methods to identify service gaps and to ensure equitable use of State funds to fill those gaps among all counties.

(c) State performance measures. – The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer-focused outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services on the State's progress in these performance areas."

SECTION 1.(b). The North Carolina Department of Health and Human Services (DHHS) shall review all State Plans for Mental Health, Developmental Disabilities, and Substance Abuse Services implemented after July 1, 2001 and before

the effective date of this act and produce a single document that contains a cumulative statement of all still applicable provisions of those Plans. This cumulative document shall constitute the State Plan until July 1, 2007.

DHHS and the Secretary shall also identify those provisions in G.S. 122C-112.1, prior State Plans, and directives or communications by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services that must be adopted as administrative rules in order to be enforceable and undertake to adopt those rules.

SECTION 2. G.S. 122C-112.1(a)(9) reads as rewritten:

"**§ 122C-112.1. Powers and duties of the Secretary.**

(a) The Secretary shall do all of the following:

. . .

(9) ~~Assist~~ Provide ongoing and focused technical assistance to area authorities and county programs in the implementation of their administrative and management functions and the establishment and operation of community-based programs. The Secretary shall include in the State Plan a mechanism for monitoring the Department's success in implementing this duty and the progress of area authorities and county programs in achieving these functions."

SECTION 3. There is appropriated from the General Fund to the Department of Health and Human Services (DHHS) the sum of one million seven hundred thousand dollars ($1,7000,000) for the 2006-2007 fiscal year to be used to hire one or more independent consultants to undertake the following tasks:

a. Assist DHHS with the strategic planning necessary to develop the revised State Plan as required under G.S. 122C-102. The State Plan shall be coordinated with local and regional crisis service plans by area authorities and county programs.

b. Study and make recommendations to increase the capacity of DHHS to implement system reform successfully and in a manner that maintains strong management functions by area authorities and county programs at the local level.

c. Assist the Division of Mental Health, Developmental Disabilities , and Substance Abuse Services to work with area authorities and county programs to:

1. Develop and implement five to ten critical performance indicators to be used to hold area authorities and county programs accountable for managing the mental health, developmental disabilities, and substance abuse services system. The performance system indicators shall be implemented no later than six months after the consultant's contract is awarded and in no event later than July 1, 2007.

2. Standardize the utilization management functions for Medicaid and non-Medicaid services and for the review and approval of person-centered plans.

3. Develop area authorities' and county programs' expertise to assume utilization management for Medicaid services. The goal shall be to have a portion of the area authorities and county programs assume that function beginning July 1, 2007 and the remainder to assume the function no later than July 1, 2009.
4. Develop a standardized operating procedure for area authorities and county programs.
5. Implement other uniform procedures for the management functions of area authorities and county programs.

d. Provide technical assistance and oversight to private service providers, area authorities, and county programs to ensure that best practices and new services are being delivered with fidelity to the service definition model.

SECTION 4. This act becomes effective July 1, 2006.

LEGISLATIVE PROPOSAL #5

STRENGTHEN LOCAL MANAGEMENT ENTITIES (LMES)

LEGISLATIVE PROPOSAL #5:

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS
TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

AN ACT TO CLARIFY AND STRENGTHEN THE ROLE OF LOCAL MANAGEMENT ENTITIES.

SHORT TITLE: **Strengthen Local Management Entities (LMEs).**

SPONSORS:

BRIEF OVERVIEW This bill would:

1. Amend Article 4 of Chapter 122C to clearly articulate the administrative and managerial functions that are the responsibility of an LME and clarify that LME functions may not be removed by the Secretary absent an individualized finding that a particular program is not providing minimally adequate services or is in imminent danger of failing financially.
2. Direct the Division to recalculate the LME systems management allocations for SFY 2006-2007 to include funds for each LME to implement 24/7/365 screening, triage and referral and the review and approval of all person-centered plans.
3 Direct the Department to retain all funds withdrawn from the LME cost model allocations that are not accounted for in subsection 5.2 of this section and transfer the funds to LMEs to use for services.
4. Amend Article 4 of Chapter 122C to comply with the current Division practice to require that by July 1, 2007, all LMEs must have catchment areas that include at least 6 counties or a population of at least 200,000. LMEs that do not comply with this requirement will lose 10% of their administrative funding each year until mergers have been accomplished. Administrative savings realized under this provision shall be reallocated to those LMEs for services.

5. Direct the Office of State Personnel to study the job functions of area directors and finance officers and implement job classifications by December 1, 2006, that reflect the necessary skills for those positions.
6. Amend G.S. 122C-119.1 to specify that board members must receive at least 6 hours of training annually. Appropriate $20,000 (recurring) to the current training contract to implement.
7. Standardize area board membership to 3-year terms and prohibit individuals from serving more than 2 consecutive terms. Amend LME board member requirements to increase participation by individuals with business and financial backgrounds and to create more flexibility as to the appointment of consumer members.
8 Amend Chapters 122C and 160A to require that the quarterly financial reports filed by LMEs with their counties must be reviewed and approved by the county finance officers.

EFFECTIVE DATE: The merger requirements for LMEs would become effective July 1, 2007. The job classifications for LME director and finance officer would become effective January 1, 2007 and apply to persons hired on or after that date. The remainder of the bill would become effective July 1, 2006.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

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BILL DRAFT 2005-RCz-18 [v.10] (03/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/9/2006 4:58:39 PM

Short Title: Strengthen Local Management Entities (LMEs).	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO CLARIFY AND STRENGTHEN THE ROLE OF LOCAL MANAGEMENT ENTITIES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-3 is amended by adding a new subdivision to read:

"**§ 122C-3. Definitions.**

~~As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:~~The following definitions apply in this Chapter:

. . .

(20b) "Local management entity" or "LME" means an area authority, county program or consolidated human services agency. An LME is not a unit of local government and the term refers to functional responsibilities rather than governance structure."

SECTION 2. G.S. 122C-111 reads as rewritten:

"**§ 122C-111. Administration.**

The Secretary shall administer and enforce the provisions of this Chapter and the rules of the Commission and shall operate State facilities. An area director or program director shall (i) manage the public mental health, developmental disabilities and substance abuse system for ~~administer the programs of~~ the area authority or county ~~program, as applicable,~~ program according to the local business plan, and (ii) enforce applicable State laws, rules of the Commission, and rules of the Secretary. The Secretary in cooperation with area and county program directors and State facility directors shall provide for the coordination of public services between area authorities, county programs, and State facilities. The area authority or county program shall

monitor the provision of mental health, developmental disability, and substance abuse services for compliance with the law, which monitoring shall not supercede or duplicate the regulatory authority or functions of agencies of the Department."

SECTION 3. G.S. 122C-115.2(a) reads as rewritten:

"**§ 122C-115.2.** ~~Business~~ LME business plan required; content, process, certification.

(a) Every county, through an area authority or county program, shall provide for the development, review, and approval of ~~a~~ an LME business plan for the management and delivery of mental health, developmental disabilities, and substance abuse services. ~~A~~ An LME business plan shall provide detailed information on how the area authority or county program will meet State standards, laws, and rules for ensuring quality mental health, developmental disabilities, and substance abuse services, including outcome measures for evaluating program effectiveness. The business plan shall be in effect for at least three State fiscal years."

SECTION 4. Article 4 of Chapter 122C is amended by adding a new section to read:

"**§ 122C-115.4. Responsibilities of local management entities.**

(a) Local management entities are responsible for the administration and management of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME plans, develops, implements and monitors services within a specified geographic area for both insured and uninsured individuals.

(b) The core functions of an LME include all of the following:

(1) Access for all citizens to core services through the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider endorsement, monitoring, technical assistance, and capacity development. An LME may remove as a choice a provider who fails to meet defined quality criteria or fails to provide data required for monitoring client outcomes.

(3) Utilization review and determination of the appropriate level and intensity of services for all State-funded services, authorization of recipients of services under a Medicaid waiver, review and approval of all person-centered plans, utilization management for all services, care coordination, quality management, and authorization of State psychiatric hospital and other State facility bed days.

(4) Community collaboration and consumer affairs including assurance of rights, appeals, establishment and support for an effective consumer and family advisory committee.

(5) Financial management and accountability including information management for the delivery of publicly funded services for mental illness, developmental disabilities, and substance abuse.

(c) An area authority, county program may contract with any public or private entity for the implementation of some or all of the LME responsibilities articulated under this section. A consolidated human services agency may contract with any public or private entity for the implementation of some or all of the LME responsibilities

subject to the requirements of G.S. 122C-127. The Secretary may not remove any responsibility enumerated under subsection (b) of this section absent an individualized finding that a particular area authority or county program is not providing minimally adequate services under G.S. 122C-124.1 or is in imminent danger of failing financially under G.S. 122C-125. The notice and procedural requirements of G.S. 122C-124.1 and 122C-125 shall apply to the findings."

SECTION 4.1. Effective July 1, 2009. G.S. 122C-115.4(b) as enacted in Section 4 of this act reads as rewritten:

"(b) The core functions of an LME include all of the following:

(1) Access for all citizens to core services through the implementation of a 24-hour a day, seven-days a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider endorsement, monitoring, technical assistance, and capacity development. An LME may remove as a choice a provider who fails to meet defined quality criteria or fails to provide data required for monitoring client outcomes.

(3) Utilization review and determination of the appropriate level and intensity of services for all ~~state-funded~~ services, authorization of recipients of services under a Medicaid waiver, review and approval of all person-centered plans, utilization management for all services, care coordination, quality management, and authorization of State psychiatric hospital and other State facility bed days.

(4) Community collaboration and consumer affairs including assurance of rights, appeals, establishment and support for an effective consumer and family advisory committee.

(5) Financial management and accountability including information management for the delivery of publicly funded services for mental illness, developmental disabilities, and substance abuse."

SECTION 5. G.S. 122C-112.1(a) reads as rewritten:

"§ 122C-112.1. Powers and duties of the Secretary.

(a) The Secretary shall do all of the following:

(1) Oversee development of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) Enforce the provisions of this Chapter and the rules of the Commission and the Secretary.

(3) Establish a process and criteria for the submission, review, and approval or disapproval of LME business plans submitted by area authorities and counties for the management and provision of mental health, developmental disabilities, and substance abuse services.

(4) Adopt rules specifying the content and format of LME business plans.

(5) Review business plans and, upon approval of the LME business plan, certify the submitting area authority or county program to provide mental health, developmental disabilities, and substance abuse ~~services.~~ in the applicable catchment area.

(6) Establish comprehensive, cohesive oversight and monitoring procedures and processes to ensure continuous compliance by area authorities, county programs, and all providers of public services with State and federal policy, law, and standards. Procedures shall include performance measures and report cards for each area authority and county program.

(7) Conduct regularly scheduled monitoring and oversight of area authority, county programs, and all providers of public services. Monitoring and oversight shall include compliance with the program business plan, core administrative functions, and fiscal and administrative practices and shall also address outcome measures, consumer satisfaction, client rights complaints, and adherence to best practices.

(8) Make findings and recommendations based on information and data collected pursuant to subdivision (7) of this subsection and submit these findings and recommendations to the applicable area authority board, county program director, board of county commissioners, providers of public services, and to the Local Consumer Advocacy Office.

(9) Assist area authorities and county programs in the establishment and operation of community-based programs.

(10) Operate State facilities and adopt rules pertaining to their operation.

(11) Develop a unified system of services provided ~~in area, county, and~~ at the community level, by State facilities, and by providers enrolled or under a contract with the ~~State.~~State and an area authority or county program.

(12) Adopt rules governing the expenditure of all funds for mental health, developmental disabilities, and substance abuse programs and services.

(13) Adopt rules to implement the appeal procedure authorized by G.S. 122C-151.2.

(14) Adopt rules for the implementation of the uniform portal process.

(15) Except as provided in G.S. 122C-26(4), adopt rules establishing procedures for waiver of rules adopted by the Secretary under this Chapter.

(16) Notify the clerks of superior court of changes in the designation of State facility regions and of facilities designated under G.S. 122C-252.

(17) Promote public awareness and understanding of mental health, mental illness, developmental disabilities, and substance abuse.

(18) Administer and enforce rules that are conditions of participation for federal or State financial aid.

(19) Carry out G.S. 122C-361.

(20) Monitor the fiscal and administrative practices of area authorities and county programs to ensure that the programs are accountable to the State for the management and use of federal and State funds allocated

for mental health, developmental disabilities, and substance abuse services. The Secretary shall ensure maximum accountability by area authorities and county programs for rate-setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping, documentation, and other matters pertaining to financial management and fiscal accountability. The Secretary shall further ensure that the practices are consistent with professionally accepted accounting and management principles.

(21) Provide technical assistance, including conflict resolution, to counties in the development and implementation of area authority and county program business plans and other matters, as requested by the county.

(22) Develop a methodology to be used for calculating county resources to reflect cash and in-kind contributions of the county.

(23) Adopt rules establishing program evaluation and management of mental health, developmental disabilities, and substance abuse services.

(24) Adopt rules regarding the requirements of the federal government for grants-in-aid for mental health, developmental disabilities, or substance abuse programs which may be made available to area authorities or county programs or the State. This section shall be liberally construed in order that the State and its citizens may benefit from the grants-in-aid.

(25) Adopt rules for determining minimally adequate services for purposes of G.S. 122C-124.1 and G.S. 122C-125.

(26) Establish a process for approving area authorities and county programs to provide services directly in accordance with G.S. 122C-141.

(27) Sponsor training opportunities in the fields of mental health, developmental disabilities, and substance abuse.

(28) Enforce the protection of the rights of clients served by State facilities, area authorities, county programs, and providers of public services.

(29) Adopt rules for the enforcement of the protection of the rights of clients being served by State facilities, area authorities, county programs, and providers of public services.

(30) Prior to requesting approval to close a State facility under G.S. 122C-181(b):

a. Notify the Joint Legislative Commission on Governmental Operations, the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and members of the General Assembly who represent catchment areas affected by the closure; and

b. Present a plan for the closure to the members of the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and

Human Services, and the Senate Appropriations Committee on Health and Human Services for their review, advice, and recommendations. The plan shall address specifically how patients will be cared for after closure, how support services to community-based agencies and outreach services will be continued, and the impact on remaining State facilities. In implementing the plan, the Secretary shall take into consideration the comments and recommendations of the committees to which the plan is presented under this subdivision.

(31) Ensure that the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services is coordinated with the Medicaid State Plan and NC Health Choice.

(32) Remove area authority and county program board members who do not comply with the training requirements of G.S. 122C-119.1."

SECTION 6. G.S. 122C-115.1(a) reads as rewritten:

"**§ 122C-115.1. County governance and operation of mental health, developmental disabilities, and substance abuse services program.**

(a) A county may operate a county program for mental health, developmental disabilities, and substance abuse services as a single county or, pursuant to Article 20 of Chapter 160A of the General Statutes, may enter into an interlocal agreement with one or more other counties for the operation of a multicounty program. An interlocal agreement shall provide for the following:

(1) Adoption and administration of the program budget in accordance with Chapter 159 of the General Statutes.

(2) Appointment of a program director to carry out the provisions of G.S. 122C-111 and duties and responsibilities delegated by the county. ~~Except when specifically waived by the Secretary, the program director shall meet the following minimum qualifications:~~

~~a. Masters degree,~~

~~b. Related experience, and~~

~~c. Management experience.~~

(3) A targeted minimum population of 200,000 or a targeted minimum number of five counties served by the program.

(4) Compliance with the provisions of this Chapter and the rules of the Commission and the Secretary.

(5) Written notification to the Secretary prior to the termination of the interlocal agreement.

(6) Appointment of an advisory committee. The interlocal agreement shall designate a county manager to whom the advisory committee shall report. The interlocal agreement shall also designate the appointing authorities. The appointing authorities shall make appointments that take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of

participating counties. ~~At least fifty percent (50%) of the~~ The membership shall conform to the requirements provided in G.S. 122C-118.1(b)(1)-(4)."

SECTION 7. Effective July 1, 2007, G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to G.S. 122C-115.1. The catchment area of an area authority or a county program shall contain either a minimum population of at least 200,000 or a minimum of six counties. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 8. Effective July 1, 2007, G.S. 122C-115.1(a) as amended by Section 6 of this act, reads as rewritten:

"**§ 122C-115.1. County governance and operation of mental health, developmental disabilities, and substance abuse services program.**

(a) A county may operate a county program for mental health, developmental disabilities, and substance abuse services as a single county or, pursuant to Article 20 of Chapter 160A of the General Statutes, may enter into an interlocal agreement with one or more other counties for the operation of a multicounty program. An interlocal agreement shall provide for the following:

(1) Adoption and administration of the program budget in accordance with Chapter 159 of the General Statutes.

(2) Appointment of a program director to carry out the provisions of G.S. 122C-111 and duties and responsibilities delegated by the county.

~~(3) A targeted minimum population of 200,000 or a targeted minimum number of five counties served by the program.~~

(4) Compliance with the provisions of this Chapter and the rules of the Commission and the Secretary.

(5) Written notification to the Secretary prior to the termination of the interlocal agreement.

(6) Appointment of an advisory committee. The interlocal agreement shall designate a county manager to whom the advisory committee shall report. The interlocal agreement shall also designate the appointing authorities. The appointing authorities shall make appointments that take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. The membership shall conform to the requirements provided in G.S. 122C-118.1(b)(1)-(4)."

SECTION 9. Effective January 1, 2007, G.S. 122C-115.1(f) reads as rewritten:

"(f) In a single-county program, the program director shall be appointed by the county manager. In a multicounty program, the program director shall be appointed in accordance with the terms of the interlocal agreement.

Except when specifically waived by the Secretary, the program director shall meet all the following minimum qualifications:

(1) Masters degree.

(2) Related experience.

(3) Management experience.

(4) Any other qualifications required under the job classification adopted by the State Personnel Commission."

SECTION 10. Effective January 1, 2007, G.S. 122C-121(d) reads as rewritten:

"(d) Except when specifically waived by the Secretary, the area director shall meet all the following minimum qualifications:

(1) Masters ~~degree;~~degree.

(2) Related ~~experience; and~~ experience.

(3) Management experience.

(4) Any other qualifications required under the job classification adopted by the State Personnel Commission."

SECTION 11. G.S. 122C-117(c) reads as rewritten:

"(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide to the finance officer of the county, or in the case of a multicounty area authority the finance officers of each county, the quarterly report of the area authority. The report shall include a budgetary statement and balance sheet that details the assets, liabilities, and fund balance of the area authority. The county finance officer shall review the report and may make comments regarding the finances of the area authority before the report is provided to each member of the board of county commissioners ~~the quarterly report~~ of the area authority. This information shall be presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners."

SECTION 13. G.S. 122C-115.1(e) reads as rewritten:

"(e) Within 30 days of the end of each quarter of the fiscal year, the program director and finance officer of the county program shall present to the finance officer of the county, or in the case of a multicounty program the finance officers of each county, the quarterly report of the county program. The report shall include a budgetary statement and balance sheet that details the assets, liabilities, and fund balance of the county program. The county finance officer shall review the report and may make comments regarding the finances of the program before the report is provided to each member of the board of county commissioners ~~a budgetary statement and balance sheet that details the assets, liabilities, and fund balance of the county program.~~ This information shall be read into the minutes of the meeting at which it is presented. The program director or finance officer of the county program shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners."

SECTION 13. G.S. 122C-119.1 reads as rewritten:

"**§ 122C-119.1. Area Authority and county program board members' training.**

All members of the governing body for an area authority shall receive ~~initial orientation on board members' responsibilities and training provided by the Department in~~ at least six hours of training per year regarding board members' responsibilities, as well as fiscal management, budget development, and fiscal accountability. The Department, the Council of Community Programs, the North Carolina Association of County Commissioners and the School of Government at the University of North Carolina at Chapel Hill shall collaborate in the development and delivery of the training. ~~A member's refusal to be trained shall be grounds for removal from the board.~~ The Secretary shall monitor board member attendance and shall remove any member who fails to comply with this section. "

SECTION 14. G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) An area board shall have no fewer than 11 and no more than 25 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation~~, equitable~~ representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include an individual with financial ~~expertise or~~ expertise, a county finance officer, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~At least~~ Not more than fifty percent (50%) of the members of the area board shall represent the following:

(1) A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.

(2) A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.

(3) ~~A~~ At least one family member or ~~an~~ individual from a citizens' ~~organizations~~ organization composed primarily of consumers or their family members, representing the interests of individuals:

a. With mental illness; ~~and~~
b. In recovery from addiction; ~~and~~ or
c. With developmental disabilities.

(4) ~~Openly~~ At least one openly declared ~~consumers:~~consumer:
a. With mental illness; ~~and~~
b. With developmental ~~disabilities; and~~ disabilities; or
c. In recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently more than one category of membership if the member has the qualifications or attributes of more than one category of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity. The terms of county commissioners on an area board are concurrent with their terms as county commissioners. The terms of the other members on the area board shall be for ~~four~~ three years, except that upon the initial formation of an area board ~~one-fourth~~ one-third shall be appointed for one year, ~~one-fourth~~ one-third for two years, ~~one-fourth for three years,~~ and all remaining members for ~~four~~ three years. Members ~~other than county commissioners~~ shall not be appointed for more than two consecutive terms. Board members serving as of July 1, 2006 may remain on the board for one additional term.

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 15. G.S. 122C-115.1(g) reads as rewritten:

"(g) In a single-county program, an advisory committee shall be appointed by the board of county commissioners and shall report to the county manager. The appointments shall take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. ~~At least fifty percent (50%) of the~~ The membership shall conform to the requirements in G.S. 122C-118.1(b)(1)-(4). In a multicounty program, the advisory committee shall be appointed in accordance with the terms of the interlocal agreement."

SECTION 16. G.S. 122C-115.1(i) reads as rewritten:

"(i) Except as otherwise specifically provided, this Chapter applies to counties that provide mental health, developmental disabilities, and substance abuse services through a county program. As used in the applicable sections of this Article, the terms "area authority", "area program", and "area facility" shall be construed to include "county program". The following sections of this Article do not apply to county programs:

(1) G.S. 122C-115.3, 122C-116, 122C-117, and 122C-118.1.
(2) ~~G.S. 122C-119 and G.S. 122C-119.1.~~G.S. 122C-119.
(3) G.S. 122C-120 and G.S. 122C-121.
(4) G.S. 122C-127.
(5) G.S. 122C-147.
(6) G.S. 122C-152 and G.S. 122C-153.
(7) G.S. 122C-156.

(8) G.S. 122C-158."

SECTION 17. The Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for area authorities and county programs that do not comply with Sections 7 and 8 of this act. The funds withdrawn from administrative functions shall be reallocated to the same area authority or county program to be used to provide mental health, developmental disabilities, and substance abuse services.

SECTION 18. The Office of State Personnel shall develop a job classification for director of an area authority or county program that reflects the skills required of an individual operating a local management entity. The Office of State Personnel shall also review the job classifications for area authority and county program finance officers to determine whether they reflect the skills necessary to manage the finances of a local management entity. The Commission shall adopt a job classification for director and any new or revised job classifications for finance officers no later than December 31, 2006. The requirements of the job classifications shall apply to persons hired by an area authority or county program on or after January 1, 2007.

SECTION 19. The Department of Health and Human Services (Department) shall recalculate the LME systems management allocations for state fiscal year 2006-2007 to include funds for each LME to implement 24-hour, seven-days a week screening, triage and referral and the review and approval of all person centered plans. The recalculation represents **??????????** in State and federal Medicaid funds and shall be used by LMEs to implement those functions.

The Department shall also review the LME responsibilities described in G.S. 122C-115.4 in Section 4 of this act and recalculate the LME systems management allocations for state fiscal year 2006-2007 based upon those functions. To the extent there are funds that constitute any remaining reduction in the LME systems management allocation model, those funds shall be reallocated to those LMEs that will experience a reduction in their administrative budgets. The LMEs shall use the funds to provide mental health, developmental disabilities, and substance abuse services.

SECTION 20. There is appropriated from the General Fund to the Department of Health and Human Services the sum of twenty thousand dollars ($20,000) for the 2006-2007 fiscal year to provide training to area authority and county program board members under G.S 122C-119.1

SECTION 21. Unless otherwise specified, this act becomes effective July 1, 2006.

LEGISLATIVE PROPOSAL #6

CONSUMER AND FAMILY ADVISORY COMMITTEES

LEGISLATIVE PROPOSAL #6:

A RECOMMENDATION OF THE REVENUE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS
TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

AN ACT TO CODIFY PORTIONS OF THE STATE PLAN FOR MH/DD/SAS REFORM TO CREATE CONSUMER AND FAMILY ADVISORY COUNCILS AND TO APPROPRIATE FUNDS FOR IMPLEMENT THE CONSUMER ADVOCACY PROGRAM.

SHORT TITLE: **Consumer and Advisory Committees.**

SPONSORS:

BRIEF OVERVIEW: This bill would:

1. Codify local CFACS to clarify and focus their roles and responsibilities.
2. Codify the State CFAC and allocate appointments to the Secretary of DHHS, President Pro Tempore of the Senate, the Speaker of the House of Representatives, the Council of Community Programs and the Association of County Commissioners.
3. Appropriate $1,200,000 (recurring) to implement the MH/DD/SA Consumer Advocacy Program (Article 1A of Chapter 122C) as enacted in 2001.

EFFECTIVE DATE: The bill would become effective July 1, 2006.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-RCz-28 [v.3] (04/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2006 2:37:39 PM

Short Title: Consumer and Family Advisory Committees.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO CODIFY PORTIONS OF THE STATE PLAN FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES TO CREATE CONSUMER AND FAMILY ADVISORY COMMITTEES, AND TO APPROPRIATE FUNDS TO IMPLEMENT THE MH/DD/SA CONSUMER ADVOCACY PROGRAM AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 4 of Chapter 122C is amended by adding a new Part to read:

"Part 4A. Consumer and Family Advisory Committees.

"**§ 122C-170. Local Consumer and Family Advisory Committees.**

(a) Area authorities and county programs shall establish committees made up of consumers and family members to be known as Consumer and Family Advisory Committees (CFACS). A local CFAC shall be self-governing and self-directed organization that advises the area authority or county program in its catchment area on the planning and management of the local public mental health, developmental disabilities and substance abuse services system.

Each CFAC shall adopt bylaws to govern the selection and appointment of its members, their terms of service, the number of members, and other procedural matters. At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and the governing board shall execute an agreement that identifies the roles and responsibilities of each party, channels of communication between the parties, and a process for resolving disputes between the parties.

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethic composition of the catchment area. The terms of members shall be three years and no member may serve more than two consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disability and substance abuse services;

(2) Parents of minor children who are consumers of mental health, developmental disability and substance abuse services; and

(3) Parents of adult children who are severely developmentally disabled.

(c) The CFAC shall undertake all of the following:

(1) Review, comment on, and monitor the implementation of the local business plan.

(2) Identify service gaps and underserved populations.

(3) Make recommendations regarding the service array and monitor the development of additional services.

(4) Review and comment on the area authority or county program budget.

(5) Participate in all quality improvement measures and performance indicators.

(6) Submit to the State Consumer and Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, developmental disability and substance abuse services.

(d) The director of the area authority or county program shall provide sufficient staff to assist the CFAC in implementing its duties under subsection (c) of this section. The assistance shall include data for the identification of service gaps and underserved populations, training to review and comment on business plans and budgets, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

"**§ 122C-171. State Consumer and Family Advisory Committee.**

(a) There is established the State Consumer and Advisory Committee (State CAFC). The State CFAC shall be shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities and substance abuse services system.

(b) The State CFAC shall be composed of 21 members. The members shall be composed exclusively of adult consumers of mental health, developmental disability and substance abuse services; parents of minor children who are consumers of mental health, developmental disability and substance abuse services; and parents of adult children who are severely developmentally disabled. The terms of members shall be three years and no member may serve more than two consecutive terms. Vacancies shall be filled by the appointing authority. The members shall be appointed as follows:

(1) Nine by the Secretary. The Secretary's appointments shall reflect each of the disability groups. The terms shall be staggered so that terms of three of the appointees expire each year.

(2) Three by the General Assembly upon the recommendations of the President Pro Tempore of the Senate, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(3) Three by the General Assembly upon the recommendations of the Speaker of the House of Representatives, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(4) Three by the Council of Community Programs, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(5) Three by the North Carolina Association of County Commissioners, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(c) The State CFAC shall undertake all of the following:

(1) Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services.

(2) Identify service gaps and underserved populations.

(3) Make recommendations regarding the service array and monitor the development of additional services.

(4) Review and comment on the State budget for mental health, developmental disabilities and substance abuse services.

(5) Participate in all quality improvement measures and performance indicators.

(6) Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disability and substance abuse services.

(7) Provide technical assistance to local CFACs in implementing their duties.

(d) The Secretary shall provide sufficient staff to assist the State CFAC in implementing its duties under subsection (c) of this section. The assistance shall include data for the identification of service gaps and underserved populations, training to review and comment on the State Plan and departmental budget, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

(e) State CFAC members shall receive the per diem and allowances prescribed by G.S. 138-5 for State boards and commissions."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one million two hundred thousand dollars ($1,200,000) for the 2006-2007 fiscal year to implement the MH/DD/SA Consumer Advisory Program as provided in Article 1A of Chapter 122C of the General Statues.

SECTION 3. This act becomes effective July 1, 2006.

LEGISLATIVE PROPOSAL #7

STRENGTHEN MH/DD/SAS PRIVATE PROVIDERS

LEGISLATIVE PROPOSAL #7:

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS
TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

AN ACT TO ASSIST PRIVATE PROVIDERS TO DELIVER MH/DD/SA SERVICES.

SHORT TITLE: **Strengthen MH/DD/SA Private Providers Refunds.**

SPONSORS:

BRIEF OVERVIEW: This bill would:

1. Make the facility licensure requirements for outpatient substance abuse services consistent with the facility licensure requirements for outpatient mental health or developmental disability services.
2. Direct the Division to adopt:
   a. A uniform provider contract, uniform billing and claims forms, and uniform person centered plan forms to be used by all providers and all LMEs.
   b. A standard definition of what constitutes a clean claim, standardized denial codes, a standardized policy related to the coordination of benefits.
   c. A system to provide timely outcome data to LMEs.
   d. Identify other areas of standardization that could be implemented without undermining the management authority of LMEs.
3. Direct the Division to identify and eliminate processes and procedures that are duplicative or result in unnecessary paperwork and eliminate or reduce those as much as possible.

EFFECTIVE DATE: The bill would be effective when it becomes law.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-RCz-26 [v.5] (04/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/9/2006 1:33:48 PM

Short Title:	Strengthen MH/DD/SA Private Providers.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ASSIST PRIVATE PROVIDERS DELIIVERY MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-3(14) reads as rewritten:

"§ 122C-3. Definitions.

As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:

. . .

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area authority or county program. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more

adults. ~~When the services offered are provided to individuals who are mentally ill or developmentally disabled, these~~ These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. ~~When the services offered are provided to individuals who are substance abusers, these services shall include all outpatient services, day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more.~~ Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;

e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;

f. A "State facility", which is a facility that is operated by the Secretary;

g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers."

SECTION 2. G.S. 122C-112.1(a) is amended by adding a new subdivision to read:

"§ 122C-112.1. Powers and duties of the Secretary.

(a) The Secretary shall do all of the following:

. . .

(31) Implement standard forms, contracts, processes and procedures to be used by all area authorities and county programs with other public and private service providers. These processes and procedures shall include standardized denial codes and a standard policy regarding the coordination of benefits. The Secretary shall consult with area authorities and county programs regarding the development of these forms, contracts, processes and procedures. Any document or process developed under this subsection shall place an obligation upon providers to transmit to area authorities and county programs timely

client information and outcome data. The Secretary shall also adopt rules regarding what constitutes a clean claim for purposes of billing. When implementing this subdivision, the Secretary shall balance the need for area authorities and county programs to exercise discretion in the discharge of their management responsibilities with the need of private service providers for a uniform system of doing business with public entities. The Secretary shall also (i) identify other areas of standardization that may be implemented without undermining the authority of area authorities and county programs, and (ii) identify and eliminate processes and procedures that are duplicative or result in unnecessary paperwork."

SECTION 3. G.S. 122C-142(a) reads as rewritten:

"§ 122C-142. Contract for services.

(a) When the area authority contracts with persons for the provision of services, the ~~area authority~~ it shall use the standard contract adopted by the Secretary and shall assure that these contracted services meet the requirements of applicable State statutes and the rules of the Commission and the Secretary. However, an area authority or county program may amend the contract to comply with any court-imposed duty or responsibility. Terms of the standard contract shall require the area authority to monitor the contract to assure that rules and State statutes are met. It shall also place an obligation upon the entity providing services to provide to the area authority timely data regarding the clients being served, the services provided and the client outcomes. The Secretary may also monitor contracted services to assure that rules and State statutes are met."

SECTION 4. This act is effective when it becomes law.

LEGISLATIVE PROPOSAL #8

STRENGTHEN LOC OVERSIGHT ROLE

LEGISLATIVE PROPOSAL #8:

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS
TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

AN ACT TO STRENGTHEN THE OVERSIGHT ROLE OF THE LOC, TO DIRECT THE LOC TO STUDY CERTAIN ISSUES, AND TO REPEAL THE STUDY COMMISSION ON MH/DD/SAS.

SHORT TITLE: Strengthen LOC Oversight Role.

SPONSORS:

BRIEF OVERVIEW: The bill would:

1 Direct the LOC to study

a. Mechanisms to allow LMEs to purchase bed days from the State psychiatric hospitals.

b. Whether implementation of a Medicaid 1915(b) waiver on a State-wide or expanded basis would strengthen the ability of LMEs to manage the MH/DD/SA system.

c. Whether to consolidate age and disability funding categories.

2. Amend Article 27 of Chapter 120 to make the LOC's oversight powers consistent with those of other oversight committees.

3 Repeal the Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services.

EFFECTIVE DATE: The bill would become effective July 1, 2006.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-RCz-27 [v.3] (04/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2006 2:40:46 PM

Short Title: Strengthen LOC Oversight Role.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO STRENGTHEN THE OVERSIGHT ROLE OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES; TO REPEAL THE LEGISLATIVE STUDY COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES; TO DIRECT THE OVERSIGHT COMMITTEE TO STUDY CERTAIN ISSUES; AND TO MAKE A RECOMMENDATION REGARDING INCREASING HEALTH CARE COVERAGE TO INCLUDE MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 27 of Chapter 120 is amended by adding a new section to read:

"**§ 120-244. Committee authority.**

The Committee may obtain information and data from all State officers, agents, agencies, and departments, while in discharge of its duties, under G.S. 120-19, as if it were a committee of the General Assembly. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a committee of the General Assembly. Any cost of providing information to the Committee not covered by G.S. 120-19.3 may be reimbursed by the Committee from funds appropriated to it for its continuing study."

SECTION 2. Article 23 of Chapter 120 is repealed.

SECTION 3. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) shall study the

following issues and report its findings and recommendations to the 2007 Regular Session of the 2007 General Assembly:

a. Mechanisms to allow area authorities and county programs to purchase bed days from the State psychiatric hospitals. The LOC shall consider options for holding area authorities and county programs accountable for their use of State psychiatric institutions, provide incentives to increase community capacity, and options for ensuring the State institutions have a sufficient funding stream to ensure quality care to patients and a stable and well qualified workforce.

b. Whether implementation of a Medicaid 1915(b) waiver on a State-wide or expanded local basis would strengthen the ability of area authorities and county programs to manage the mental health, developmental disabilities and substance abuse system. As part of the study, the LOC shall examine the impact of the waiver on Piedmont Behavioral Health's ability to implement its management functions including utilization management for Medicaid services, consumer satisfaction, provider monitoring, use of best practices, and any other matters the LOC determines are relevant. If the LOC determines that a Medicaid 1915(b) waiver would improve the management capacity of area authorities and county programs, it shall also examine whether it would be more appropriate to seek a State-wide waiver, or whether it would be both possible advisable for additional area authorities and county programs to seek individual waivers.

c. Whether G.S. 122C-147.1 should be amended to modify or repeal the provisions that place funds appropriated by the General Assembly into broad age and disability categories.

SECTION 4. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services recommends that the General Assembly adopt legislation that would increase the scope of health insurance coverage for individuals who have health insurance to include benefits for mental health and substance abuse services.

SECTION 5. This act is effective when it becomes law.

LEGISLATIVE PROPOSAL #9

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SAS

TO THE 2005 GENERAL ASSEMBLY, 2006 SESSION

THAT PRIVATE AND PUBLIC INSURERS PROVIDE INCREASED INSURANCE COVERAGE FOR SERVICES, INCLUDING TREATMENT FOR MENTAL ILLNESS AND SUBSTANCE ABUSE.

APPENDIX A

AUTHORIZING LEGISLATION
ARTICLE 27 OF CHAPTER 120
OF THE
GENERAL STATUTES

Article 27.
The Joint Legislative Oversight Committee On Mental Health, Developmental Disabilities, and Substance Abuse Services.

§ 120-240. Creation and membership of Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(a) Establishment; Definition. – There is established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Membership. – The Committee shall consist of 16 members, as follows:

(1) Eight members of the Senate appointed by the President Pro Tempore of the Senate, as follows:

a. At least two members of the Senate Committee on Appropriations.

b. The chair of the Senate Appropriations Committee on Human Resources.

c. At least two members of the minority party.

(2) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives, as follows:

a. At least two members of the House of Representatives Committee on Appropriations.

b. The cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.

c. At least two members of the minority party.

(c) Terms. – Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment. (2000-83, s. 2.)

§ 120-241. Purpose of Committee.

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered.

The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians. (2000-83, s. 2.)

§ 120-242. Organization of Committee.

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee. (2000-83, s. 2.)

§ 120-243. Reports to Committee.

Whenever the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is required by law to report to the General Assembly or to any of its permanent committees or subcommittees on matters affecting mental health, developmental disabilities, and substance abuse services, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. (2003-58, s. 4.)

APPENDIX B

SPENDING PROPOSALS

LOC Proposal	Recurring	Non-Recurring	Total
State Service Dollars for Developmental Therapies for Individuals with Developmental Disabilities	29,435,119		29,435,119
State Service Dollars Per Capita for Mental Health	21,726,570		21,726,570
State Service Dollars Per Capita for Substance Abuse	21,726,570		21,726,570
Operating Cost Subsidy - 400 Apartment Housing Initiative		12,050,830	12,050,830
Housing Trust Fund - 400 Apartment Housing Initiative		11,250,000	11,250,000
Supportive Services Funding and Start-up Funding for HUD-Financed Apartments and Group Homes	713,000	370,000	1,083,000
Mental Health Trust Fund for Community-Based Services		20,000,000	20,000,000
Hospital Debt Service	6,206,680		6,206,680
Start-Up Funding for Crisis Services		10,500,000	10,500,000
State Service Dollars Per Capita for Crisis Services	9,000,000		9,000,000
Per Capita Funding for Psychiatrist Access	9,000,000		9,000,000
Funding to AHEC/Rural Health to Recruit Psychiatrists	1,000,000		1,000,000
Consultants		2,125,000	2,125,000
LME Board Member Training	20,000		20,000
Consumer Advocacy Program	1,200,000		1,200,000
Total:	**$ 100,027,939**	**$ 56,295,830**	**$156,323,769**